

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10550

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 5815 Livingston Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle Mary Last Ahrendt				4. DATE OF DEATH Month September Day 23 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-04			
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York			
13. FATHER'S NAME Frederick Sonnick				14. MOTHER'S MAIDEN NAME Anna Kind					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address Mrs. Winifred Covell, Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Carcinoma of the ovary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour _____ a. m. _____ p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-24 to 9-24 , 19 60 , that (I) (we) last saw the deceased alive on 9-24 , 19 60 , and that death occurred at 11:35 p.m. , from the causes and on the date stated above.									
22a. SIGNATURE Ronald S. Fleischer M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22a. PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER				22b. ADDRESS 5432 QUEENS CHAPEL RD, N. W. WASHINGTON, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Sept 27 1960		23c. NAME OF CEMETERY OR CREMATORY Trinity Cem.		23d. LOCATION (City, town, or county) (State) Upper Marlboro Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Hallway Md.				ADDRESS _____		25a. REC'D BY REGISTRAR DATE OCT 3 '60			
						25b. REGISTRAR'S SIGNATURE O. L. S. K. K.			

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10551

10577

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE West Va. Md. b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Gen. Hosp.		d. STREET ADDRESS 7619 Atwood Street	
3. NAME OF DECEASED (Type or print) ROBERT First LEE Middle ALKIRE Last		4. DATE OF DEATH Month Sept. Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Oct 1939
9. AGE (In years birthday) 21 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbers Helper		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (State or foreign country) West Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Earl Alkire	
14. MOTHER'S MAIDEN NAME Leota Quickle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Joan Quickle (Aunt) Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Laceration + Contusion DUE TO Fractured Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) inst			INTERVAL BETWEEN ONSET AND DEATH inst
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject possessed in auto that turned over	
20c. TIME OF INJURY Hour 5:00 p. m. 9/30 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Rt. # 197 Near Laurel Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O. Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dayton O. Watkins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Oct 1, 1960	
22c. NAME OF CEMETERY OR CREMATORY Hyattsville, Md.		22d. LOCATION (City, town, or county) (State) Ham Home Clarkburg W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR OCT 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kious		DATE SIGNED 10/1/60	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

10552

10641

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hght.		c. LENGTH OF STAY IN 1b 18 Hillcrest Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2607--Gaither St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIÉ Middle J. Last ALLEN		4. DATE OF DEATH Month Sept. Day 21st Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin F. Jones		14. MOTHER'S MAIDEN NAME ? Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Beulah A. Fisher 2501--Bolton Rd. Cleveland Heights, Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of transverse colon 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Senility DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950, 19, Sept. 21st, 1960, that I last saw the deceased alive on Sept. 18, 1960, and that death occurred at 11:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Jesse B. Hopkins M.D.		M.D. 700--East Capitol St. Wash. D.C. 9-21-60	
PHYSICIAN'S NAME (Type) Dr. Jesse B. Hopkins		700--East Capitol St. Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-1960	
22c. NAME OF CEMETERY OR CREMATORY Cedarville Cemetery		22d. LOCATION (City, town, or county) (State) Cedarville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros.		ADDRESS 1661--Good Hope Rd., SE Wash. DC	
24a. REC'D BY REGISTRAR DATE SEP 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and no later than 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10553

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 20days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. STREET ADDRESS 5604 Ritchis Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Bernard Last (Alvey) Alvey				4. DATE OF DEATH Month Sept. Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> Never		8. DATE OF BIRTH 2/22/77	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Lather (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) St. Mary's, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George William Alvey				14. MOTHER'S MAIDEN NAME Mary K. Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-16-3986		17. INFORMANT George E. Alvey, 3307--79th Ave., N. Forestville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Coronary heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-vascular DUE TO Heart (c) Brain							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-28 19 60 , that (I) (we) last saw the deceased alive on 9-28 19 60 , and that death occurred on 9-28 19 60 from the causes and on the date stated above.							
22a. SIGNATURE Ronald S. Fleischer M.D.				22b. DATE SIGNED 9-28-60			
22c. PHYSICIAN'S NAME (Type) RONALD S FLEISCHER				22d. ADDRESS 5432 Queens Chapel Rd. Forestville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/1960		23c. NAME OF CEMETERY OR CREMATORY Forest M. Methodist Ch.		23d. LOCATION (City, town, or county) (State) Forestville, Pr. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 517--11th St. S.E. Wash. DC		25a. REC'D BY REGISTRAR Oct 5 60	
				25b. REGISTRAR'S SIGNATURE Arthur J. ...			

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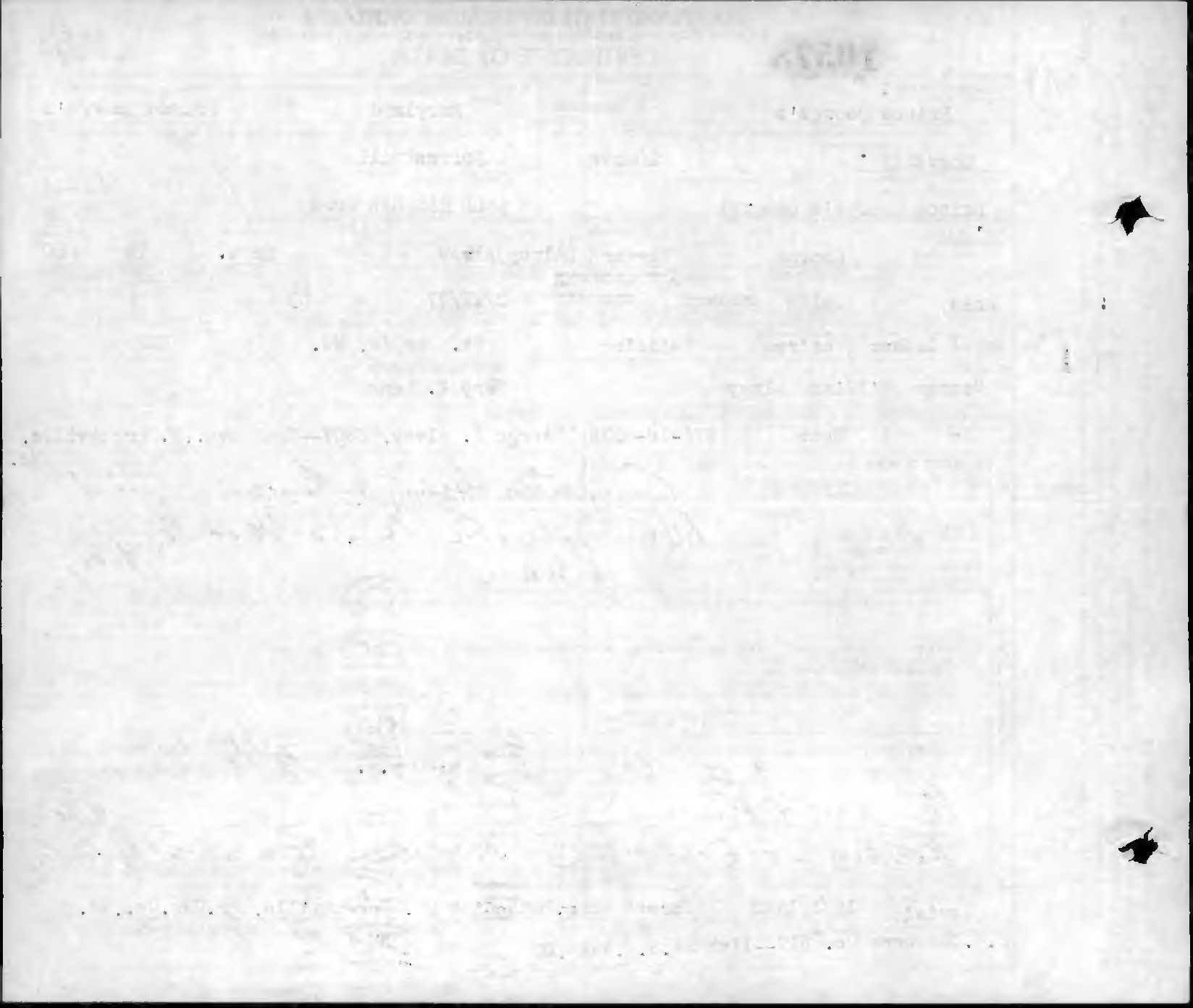
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10554

10579

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>WASH. D.C.</i> b. COUNTY <i>47 X</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EVA ELIZABETH BAISEY</i>		4. DATE OF DEATH <i>SEPT 9 1960</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>COLORED</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 2 - 1901</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR: Months <i>5</i> Days <i>9</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Ho</i>	
11. BIRTHPLACE (State or foreign country) <i>LOUISIANA, VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>THOMAS PAYNE</i>		14. MOTHER'S MAIDEN NAME <i>Unk.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unk.</i>		16. SOCIAL SECURITY NO. <i>Unk.</i>	
17. INFORMANT <i>DAUGHTER</i>		Address <i>same as H 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO <i>443X</i> Conditions, if any, which gave rise to immediate cause (b) <i>Hypertensive Cardiovascular</i> (c) <i>disease</i> DUE TO <i>disease</i> DUE TO <i>disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> a. m. <i>14</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton Watkins</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>14</i>		22b. DATE THEREOF <i>14</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter E. Hunter</i>		ADDRESS <i>2512 Sheridan Rd SE</i>	
24a. REC'D BY REGISTRAR <i>SEP 19 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10642 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Ny</u> b. COUNTY <u>Westchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5509 Birchwood Drive</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SCARSDALE</u>	
		d. STREET ADDRESS <u>334 HEATHCOTE RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Dewitt Barnhart</u>		4. DATE OF DEATH Month Day Year <u>Sept 1 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY HORNER BARNHART</u>		14. MOTHER'S MAIDEN NAME <u>ANN REYNOLDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>065-09-6015</u>	
17. INFORMANT <u>wife Alice R Barnhart</u>		Address <u>334 Heathcote Rd Scarsdale Ny</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton Watkins</u>		DATE SIGNED <u>9-1-60</u>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REBURY (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 6 '60</u>	
ADDRESS <u>Hgattsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10580

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> <i>General</i> <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. LENGTH OF STAY IN 1b <i>Doa</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Geo General</i>		d. STREET ADDRESS <i>7103 Buchanan</i>	
3. NAME OF DECEASED (Type or print) First <i>RALPH</i> Middle <i>VERNON</i> Last <i>BEALL</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>28</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Oct 30 1911</i>
9. AGE (In years last birthday) <i>48</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert T Vinton Beall</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Duwall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-03-3059</i>	
17. INFORMANT <i>Alice B Armour</i>		Address <i>4210-2nd Rd Arlington Va</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary infarction</i> <i>434.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac decompensation</i> DUE TO (c) <i>few minutes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchial asthma</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>0</i> m. <i>0</i> p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton O Watkins</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYTON OWATKINS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 1, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers & Co. Riverdale, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 3 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9, 13, 14, 15, 16, 17, 18-60 et

10643

CERTIFICATE OF DEATH

Reg. Dist. No.

10557

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs, Md. (RURAL)				c. LENGTH OF STAY IN 1b 3 HRS 20 MIN			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 21, D. C.				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital, Andrews			
d. STREET ADDRESS 2331 Lyons St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ralph Middle S. Last Beightol				4. DATE OF DEATH Month Sept. Day 30 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Nov 11	
9. AGE (In years last birthday) 48 1/2 yrs.		IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min.		IF UNDER 24 HRS. Months 17 Days 17 Hours 17 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER USAF				10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) MINNESOTA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME DECEASED Unknown				14. MOTHER'S MAIDEN NAME DECEASED Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. RECORDS		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Coronary Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 hrs (c) 2 yrs				INTERVAL BETWEEN ONSET AND DEATH 4 hrs 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JUNE , 19 59 , to September , 19 60 , that I last saw the deceased alive on 29 Sept , 19 60 , and that death occurred on 29 00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED 30 SEPTEMBER 1960							
ACTUAL SIGNATURE Edwin E. Westura M.D. USAF HOSPITAL ANDREWS							
PHYSICIAN'S NAME (Type) EDWIN E WESTURA, CAPT USAF MC				USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Oct. 4, 1960		Arlington National		Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Howard Hume, Inc.				ADDRESS 816 H St. N.E. R2		24a. REC'D BY REGISTRAR DATE OCT 4 '60	
				24b. REGISTRAR'S SIGNATURE John S. Hume			



10558

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Princ. Geo c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) X Lanham d. STREET ADDRESS Box 242 Lincoln Park • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ball First Middle Last Edna				4. DATE OF DEATH Month Day Year Sept. 29 1960			
5. SEX Fe.		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-30-01	
9. AGE (in years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME Anthony Colbert				14. MOTHER'S MAIDEN NAME Mary Skinner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [blank]		17. INFORMANT Rachel Matthews - Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Uterus DUE TO (b) with metastasis to lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yr.						INTERVAL BETWEEN ONSET AND DEATH 3 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hyattsville				20g. (County) Prince George's		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 9-18 1960 to 9-29 1960 that (I) (we) last saw the deceased alive on 9-28 1960 and that death occurred on 9-29 1960 at 8 AM , from the causes and on the date stated above							
22a. SIGNATURE Rohald S. Fleischer				22b. DATE SIGNED 9/29/60			
22c. PHYSICIAN'S NAME (Type) Rohald S. Fleischer				22d. ADDRESS 5432 Queens Chapel Road, Hyattsville			
23a. BURIAL CREMATATION OR REMOVAL (Specify) burial		23b. DATE THEREOF Oct- 3/60		23c. NAME OF CEMETERY OR CREMATORY Holy Family C. 4000		23d. LOCATION (City, town, or county) (State) Woodmore Md	
24. FUNERAL DIRECTOR'S SIGNATURE H. S. Washington				25a. REC'D BY REGISTRAR DATE OCT 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10550

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>	
c. LENGTH OF STAY IN 1b. <u>DOA-21</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hospital</u>		d. STREET ADDRESS <u>2101 T. Fairview Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES J BERRY</u>		4. DATE OF DEATH Month Day Year <u>9-16-60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-60</u>
9. AGE (In years last birthday) <u>42</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md, Pri. Geo. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Berry SR</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA Berry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>mal nutrition</u> (c) <u>—</u> DUE TO (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton Watkins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON D WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-20-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>	22d. LOCATION (City, town, or county) (State) <u>Woodmore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H S Washington</u>		24a. REC'D BY REGISTRAR <u>SEP 20 '60</u>	
ADDRESS <u>45 4925 Dore Co</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

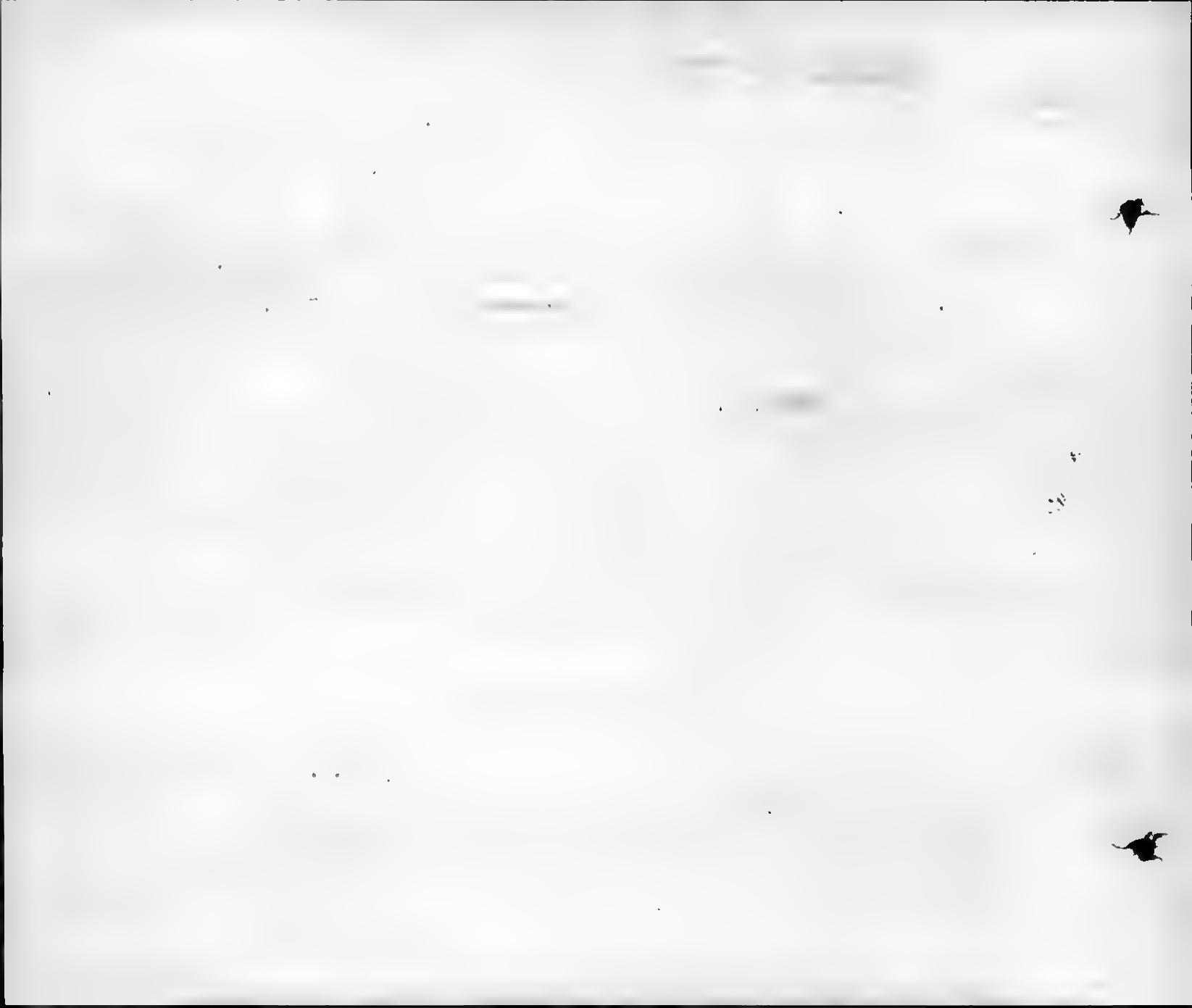
CERTIFICATE OF DEATH

10560

10583

1 PLACE OF DEATH a. COUNTY Prince George		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. STREET ADDRESS Westfailure	
3. NAME OF DECEASED (Type or print) First Joyce Middle Berry Last Berry		4. DATE OF DEATH Month Sept. Day 23 Year 1960	
5. SEX Fe.	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-60
9. AGE (in years last birthday) 6 mo. yrs		10. IF UNDER 1 YEAR: Months 6 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Prince Geo Co. Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Williams Sr.		14. MOTHER'S MAIDEN NAME Virginia Berry Forstville Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT James Williams Forstville Md		Address Forstville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) diffuse atelectasis (c) None			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 3:30 P.M. from the causes and on the date stated above			
22a SIGNATURE John G. Elders		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 3001 Church Ave, Chevy Chase Md	
23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE THEREOF 9-27-60	23c. NAME OF CEMETERY OR CREMATORY Italy Family	23d. LOCATION (City, town, or county) (State) Woodman Md
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons		25a. REC'D BY REGISTRAR SEP 28 '60	
ADDRESS 1915 Dunn		25b. REGISTRAR'S SIGNATURE William S. Thomas	

21772. JUNE 21 1960



10575

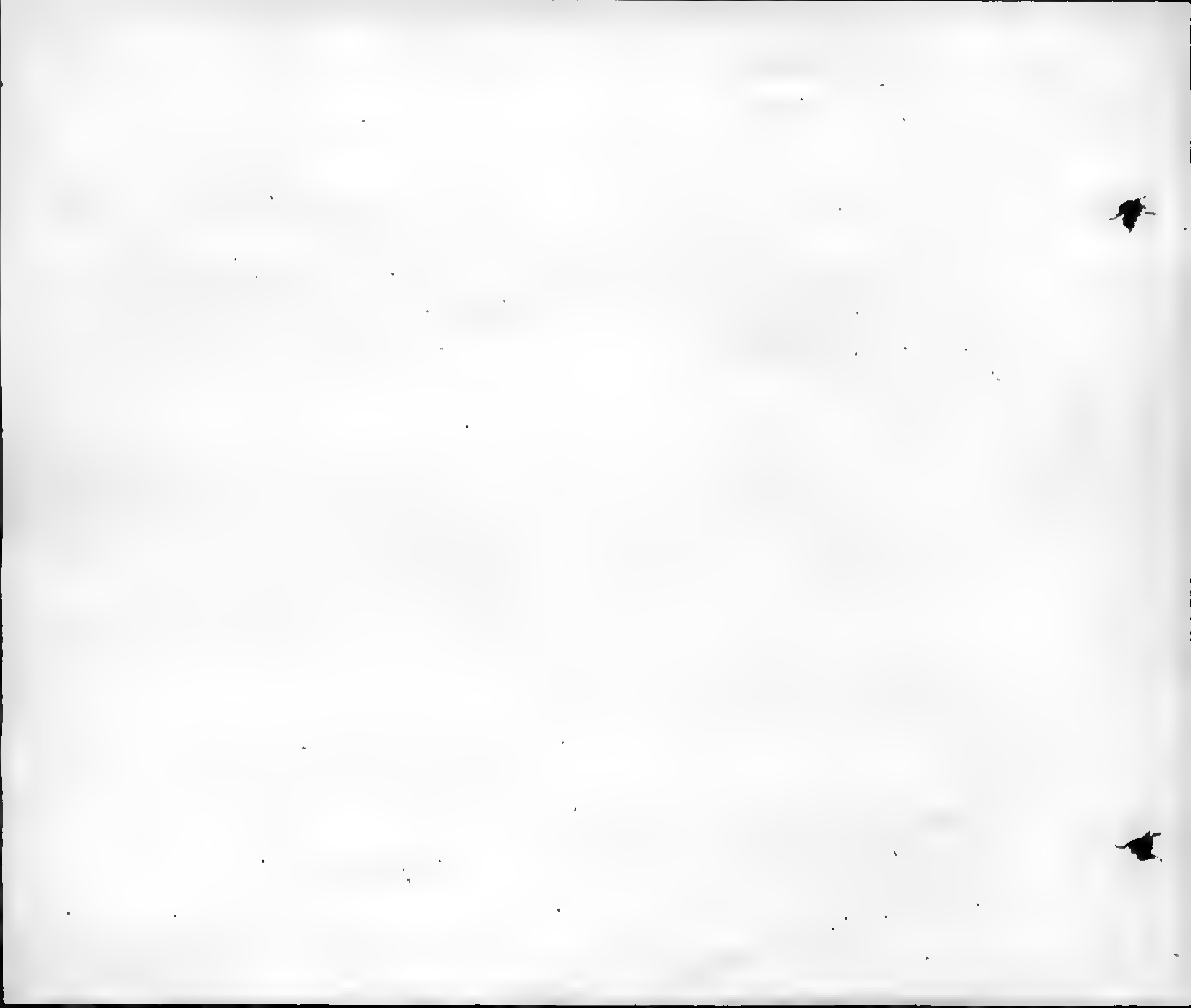
CERTIFICATE OF DEATH

Reg. Dist. No. 10561

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sakoma Park		c. LENGTH OF STAY IN lb 10 yrs		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sakoma Park		d. STREET ADDRESS 7224 Minter Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle JAMES Last BLAKER		4. DATE OF DEATH Month Sept Day 27 Year 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 6, 1870		9. AGE (In years last birthday) 89 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Police		11. BIRTHPLACE (State or foreign country) Philadelphia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Blaker		14. MOTHER'S MAIDEN NAME Claudine James		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Ruth A. Stiles (Same as #2)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422 Congestive heart failure		(b) Arteriosclerotic cardiovascular disease		(c) 5 days		INTERVAL BETWEEN ONSET AND DEATH 5 days		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Silver Spring, Md.		(County)		(State)		21. I certify that I attended the deceased from Sept. 6, 1960, to Sept. 27, 1960, that I last saw the deceased alive on Sept. 26, 1960, and that death occurred at 5:50 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 733 Sligo Ave		DATE SIGNED Sept 27, 1960		ACTUAL SIGNATURE James R. Coleman M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Philadelphia		(State) Pennsylvania		23. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters		ADDRESS 254 Carroll St NW DC		24a. REC'D BY REGISTRAR DATE SEP 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Farris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



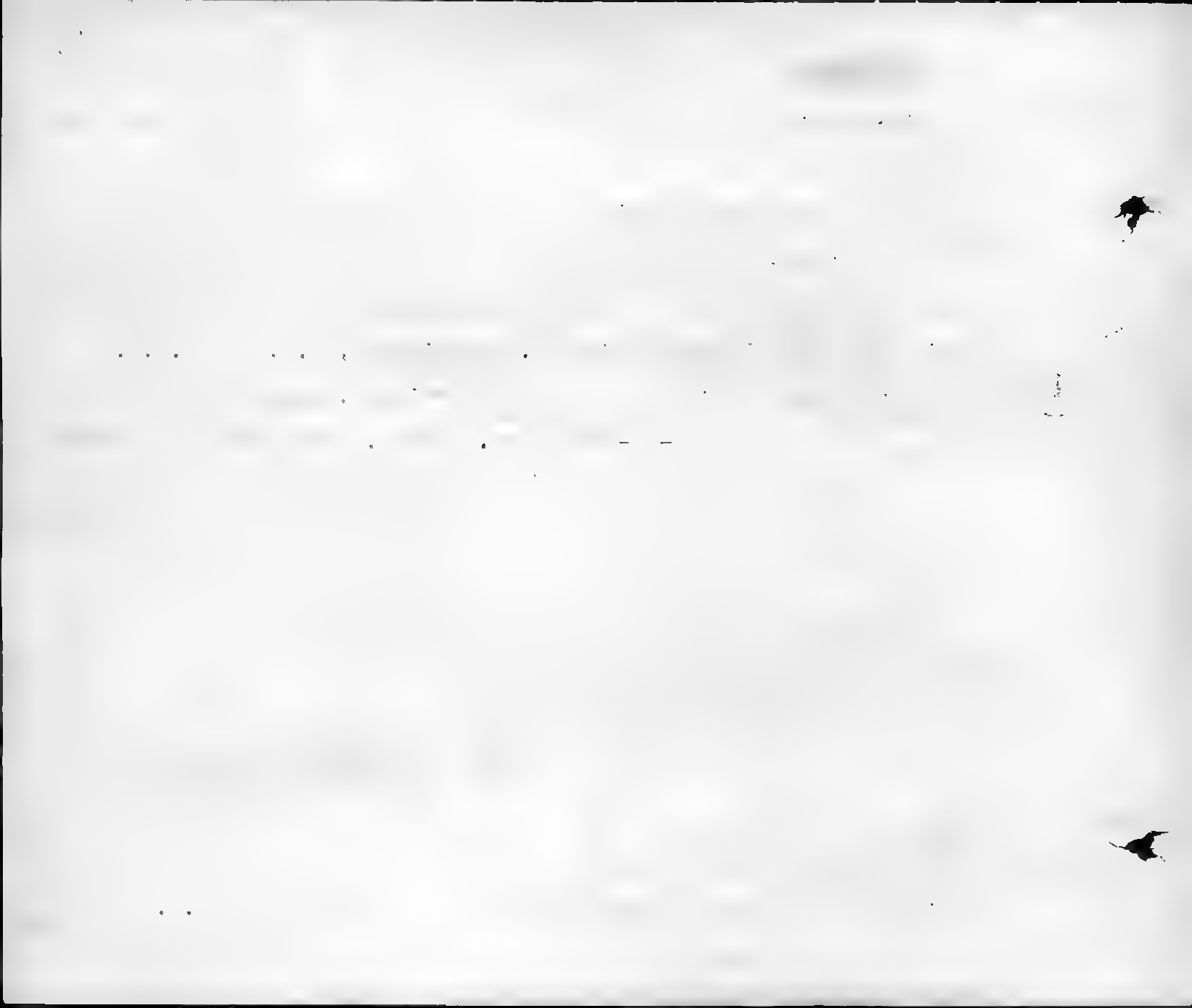
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10562

10584

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly			c. LENGTH OF STAY IN 1b 8 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4908 Lakawanna St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter , Middle Bosse , Last				4. DATE OF DEATH Month Sept Day 7 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/31/07	
9. AGE (In years last birthday) 53 yrs		10. UNDER 1 YEAR Months 53 Days 53 Hours 53 Min.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair Urns For Wilkens Coffee Co.				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
13. FATHER'S NAME Harry Vincent Bosse				14. MOTHER'S MAIDEN NAME Catherine T. Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-07-2434			
17. INFORMANT Mrs. Rose L. Bosse (Wife)				Address As above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE PULMONARY EMBOLI DUE TO PENITONITIS DUE TO Rupture of descending colon DUE TO FASTIC AND duodenal ulcer INTERVAL BETWEEN ONSET AND DEATH 12 hrs 8 days 8 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1956 to SEPT 7 1960 that (I) (we) last saw the deceased alive on SEPT 7 1960 and that death occurred at 345 PM from the causes and on the date stated above							
22a. SIGNATURE Norman Donat Bosse M.D.				22b. ADDRESS 3503 Penny St MT Rainier Md.			
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT BOSSE				22d. DATE 9/7/60			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/10/1960		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county, (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home Inc. Mt. Rainier, Md.				25a. REC'D BY REGISTRAR SEP 13 '60		25b. REGISTRAR'S SIGNATURE Robert L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10563

10637

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE c. LENGTH OF STAY IN 1b D O A d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ITELAND MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDMONSTON d. STREET ADDRESS 4904 Buchanan St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last COVIE ANN BOYER		4. DATE OF DEATH Month Day Year SEPT 15 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-60
9. AGE (in years last birthday) yrs. Months Days 12		IF UNDER 1 YEAR Months Days 12	
IF UNDER 24 HRS. Hours Min. 12		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) WASH. SAN. TAKOMA PARK MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME UNKNOWN	
14. MOTHER'S MAIDEN NAME DELORES BOYER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MOTHER Address 4904 Buchanan St. EDMONSTON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Conjunctal Heart Disease DUE TO (c) 12 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) multiple Congenital defects - Congenital dysplasia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1965	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton Watkins EXAMINER'S NAME (Type) DAYTON O. WATKINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 19 60	
24b. REGISTRAR'S SIGNATURE Charles S. House			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10644

Item 2 rimw/71 9-23-bu ec

10564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City Md</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u># 1 albview Estates</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4200 - Selmon Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY FRANCIS BOYLE</u>		4. DATE OF DEATH Month Day Year <u>Sept 9 19 60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8 1891</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER F GOETZINGER</u>		14. MOTHER'S MAIDEN NAME <u>Laura A Bechtoldt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>8-30-46046</u>	
17. INFORMANT <u>Charlotte Boyle College Park Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>diabetes</u> Interval between onset and death <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Glen Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>William L. Kinn</u>	

DATE SIGNED 9-10-60



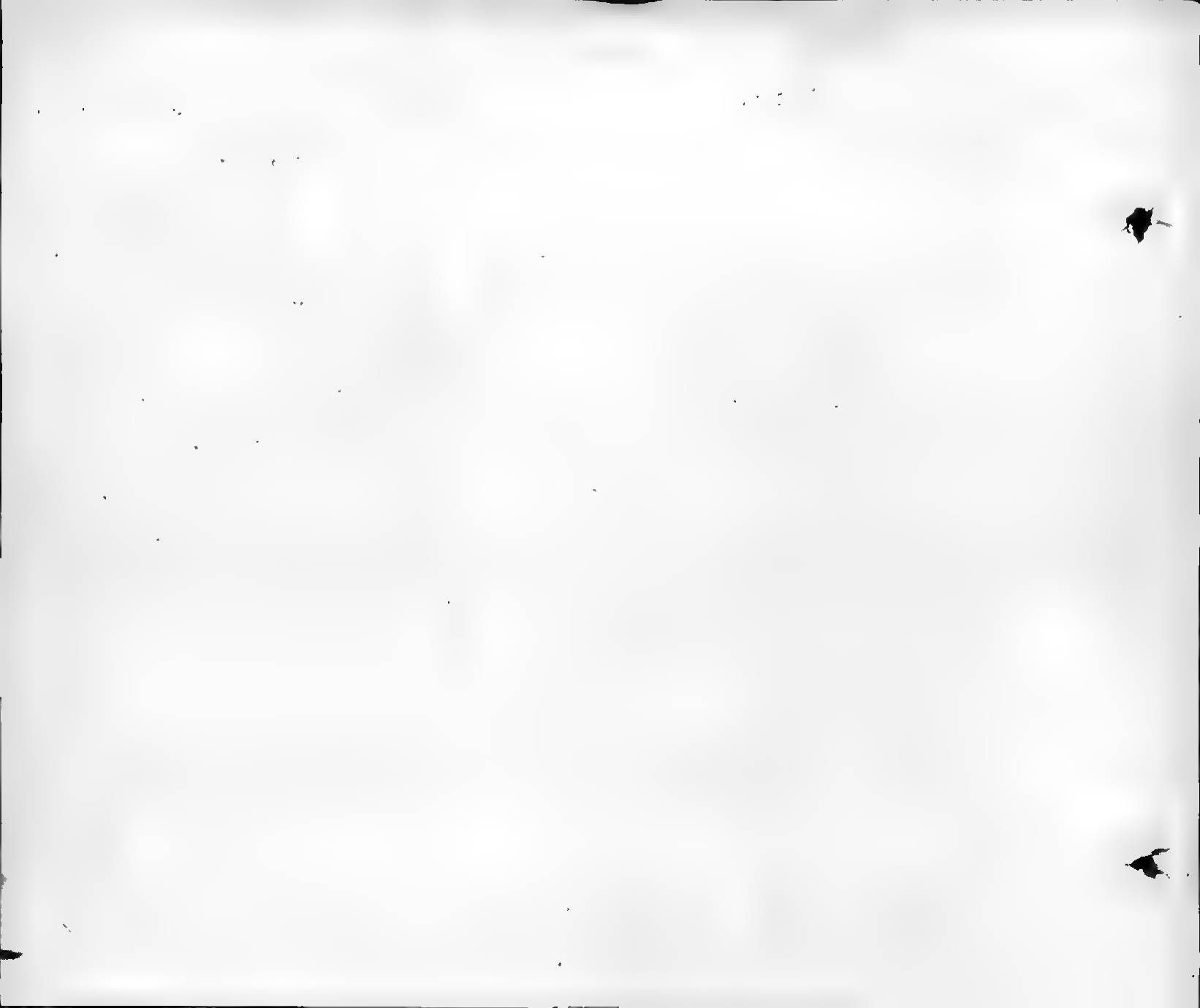
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10568 CERTIFICATE OF DEATH

10565
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4005 Jefferson Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First May Middle E Last Branson				4. DATE OF DEATH Month September Day 18 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1875	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Benjamin Pine				14. MOTHER'S MAIDEN NAME Jessie Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO no			
17. INFORMANT Ruth B Dingee				Address Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 170X DUE TO (b) Carcinoma of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 6yrs							INTERVAL BETWEEN ONSET AND DEATH 17yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1960 Hour 9:15 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1960 to Sept 18, 1960 , that I last saw the deceased alive on Sept 18, 1960 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.							DATE SIGNED 9/19/60
ACTUAL SIGNATURE Ronald S. Fleischer M.D.				ADDRESS (Street, city or town, state) 5432 QUEENS CHAPEL RD			
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER				LOCATION (City, town, or county) (State) HYATTSVILLE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 22, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		22d. LOCATION (City, town, or county) (State) Clayton New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 20 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



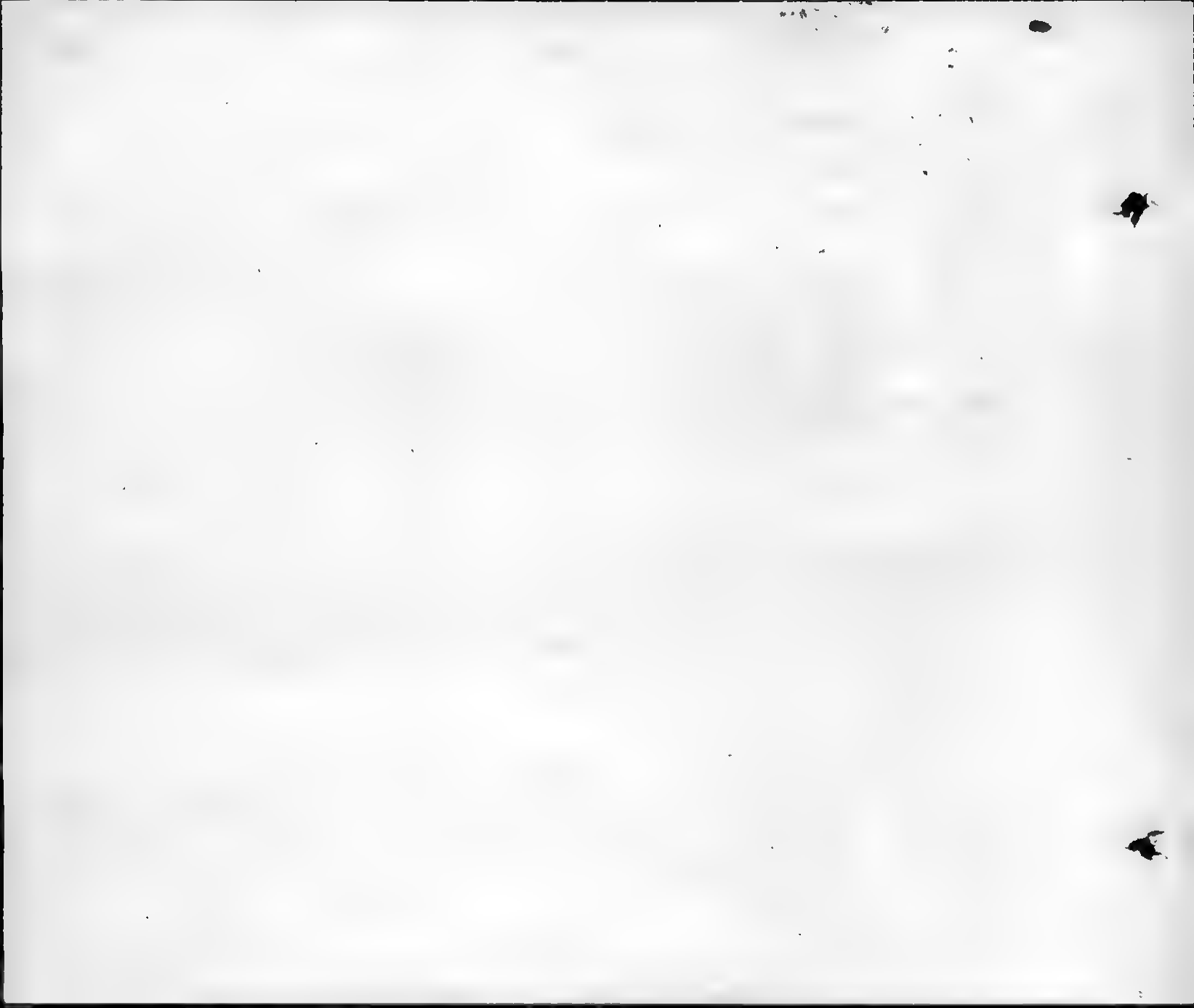
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10645
CERTIFICATE OF DEATH

Reg. Dist. No. 10566

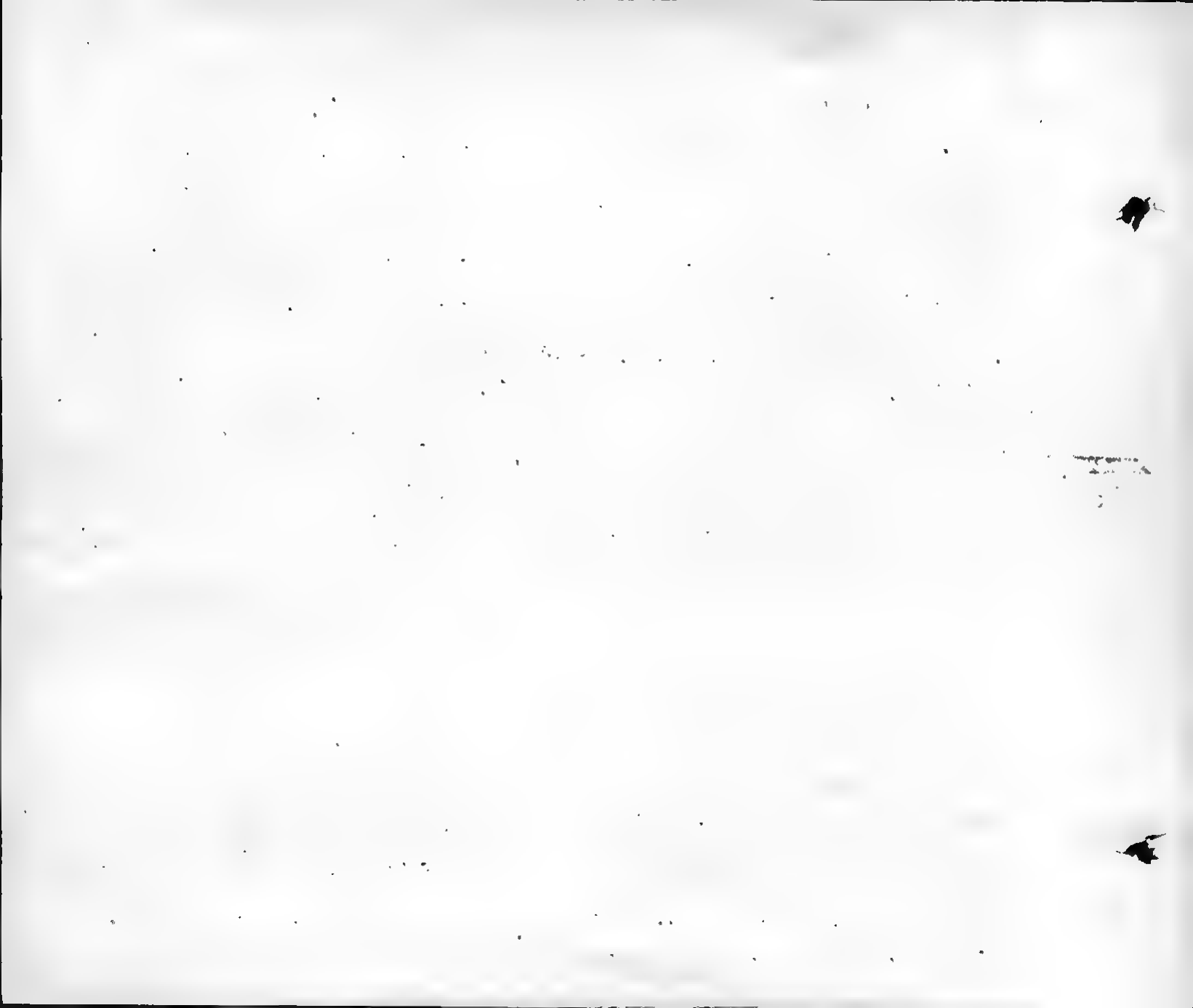
1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest - Adelphi c. LENGTH OF STAY IN 1b 14r. 5mo.		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3815 33rd St. 1	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Leone Brooks 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY HOME 11. BIRTHPLACE (State or foreign country) Troy, Ohio 12. CITIZEN OF WHAT COUNTRY? U.S.A.		4. DATE OF DEATH Month Day Year Sept. 2 1960 9. AGE (In years lost birthday) 77 yrs. 10c. BIRTHPLACE (State or foreign country) Troy, Ohio 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (Not known) Jones 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. none		14. MOTHER'S MAIDEN NAME (Not known) Drake 17. ADDRESS Prince Branch Nursing Home Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Today	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Range Bedsores following Recent Hospitalization for Pneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1, 1960, to 9-2, 1960, that I last saw the deceased alive on 8-23, 1960, and that death occurred at 8:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. 7620 Carroll Avenue Takoma Park, Md. 9-2-60			
ACTUAL SIGNATURE Stuart Nelson PHYSICIAN'S NAME (Type) STUART L. NELSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/6/60 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln 22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home Inc. ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE SEP 7 '60 24b. REGISTRAR'S SIGNATURE Christine S. Kinn	



10632 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10567
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Res. dence before address on) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper MARLBORO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADELINE W. BURROUGHS		4. DATE 9 21 19 60	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDGAR WOOD		14. MOTHER'S MAIDEN NAME SARAH HODGES CLAGETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown		16. SOCIAL SECURITY NO unknown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) several yrs (c) several yrs		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-21- , 1960, to 9-21- , 1960, that I last saw the deceased alive on 9-21- , 1960, and that death occurred at 11 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE Erika P. Kraemer		DATE SIGNED 9-21-60	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL SANITARIUM	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/24/60	
22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Croom, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE RITCHIE BROS. UPPER MARLBORO		24a. REC'D BY REGISTRAR SEP 28 '60	
ADDRESS Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hansen	



10646

CERTIFICATE OF DEATH

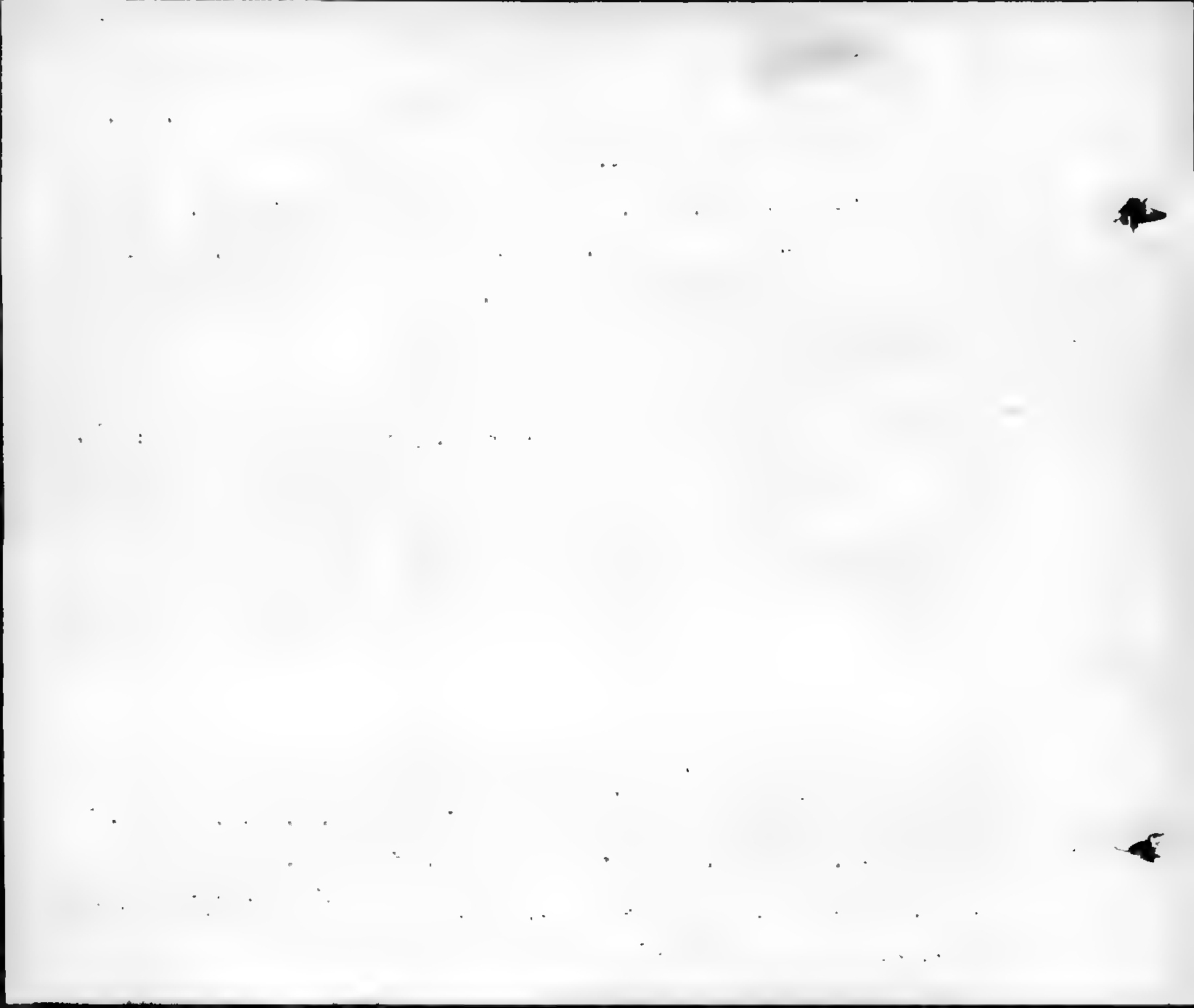
Reg. Dist. No.

10568

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 22 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108--Belgreen St., S.E.				d. STREET ADDRESS 108--Belgreen St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORAH Middle C. Last BUSSLER				4. DATE OF DEATH Month Sept. Day 5th Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 23, 1910		9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin Joy				14. MOTHER'S MAIDEN NAME Amanda Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Leonard S. Bussler 108--Belgreen St S E			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 41. DUE TO Heart Failure - Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Rheumatic Heart Disease DUE TO 30 years.						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1949, to September 5, 1960, that I last saw the deceased alive on 9-4-1960, and that death occurred at 1:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Michael J. McInerney, M.D. 1150 Conn Ave. N. W. Wash. DC Sept. 5, 60							
ACTUAL SIGNATURE Michael J. McInerney, M.D.		PHYSICIAN'S NAME (Type) Dr. Michael J. McInerney 1150 Conn. Ave., N. W. Washington DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-60		22c. NAME OF CEMETERY OR CREMATORY Washington Natl		22d. LOCATION (City, town or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Sammons Bros. 1661-20th Hope Rd SE Wash DC				24a. REC'D BY REGISTRAR DATE SEP 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Keene	

TO HOSPITAL: For ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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10585

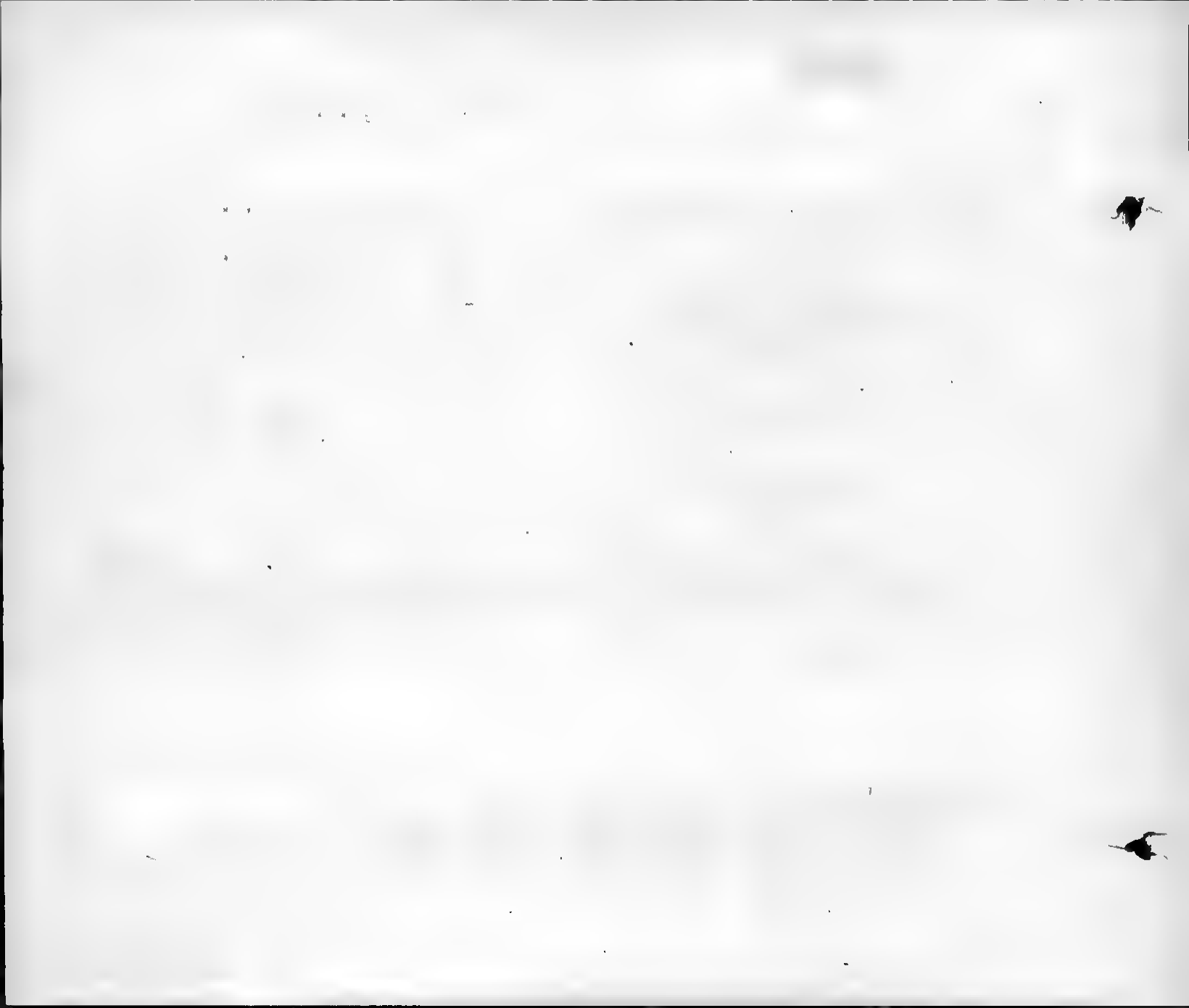
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10569

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND			2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			d. STREET ADDRESS 3064 Clinton Street, N.E.		
3 NAME OF DECEASED (Type or print) Harry L Butts			4. DATE OF DEATH Sept. 20 1960		
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-8-25		
9. AGE (In years last birthday) 75 yrs.			IF UNDER 1 YEAR: Months 75 Days 75 Hours 75 Min. 75		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer retired B. & O. R.R.			11 BIRTHPLACE (State or foreign country) Jones Springs, N. Va.		
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME George Butts		
14. MOTHER'S MAIDEN NAME Mary Margaret Kerfoot			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 705-09-1854		
16. SOCIAL SECURITY NO. 6103-2442			17. INFORMANT Margaret B. Ellison, Carrollton, Pa. Res. Md.		
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PERITONITIS DUE TO RUPTURE OF RECTUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ADENOCARCINOMA OF RECTUM (b) 3 days (c) 3 mos			INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year 19			20d. INJURY OCCURRED 19 While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from June 58 to SEPT 20 1960 , that (I) (we) last saw the deceased alive on SEPT 20 1960 , and that death occurred at 10:20 M, from the causes and on the date stated above.					
22a. SIGNATURE Norman Donat Omenac M.D.			22b. DATE SIGNED 9/20/60		
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT OMENAC			22d. ADDRESS 3503 Penny ST MT Rainier MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/60		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
23d. LOCATION (City, town, or county) (State) Colonar Manor, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Maryland			
25a. REC'D BY REGISTRAR SEP 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knead			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10570

10586

Item y m l m l 71 9-20-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN It D.O.I. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Gen. Ge. Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS Oakerest e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Edward Cager		4. DATE OF DEATH Sept. 9 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Oct 1924
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Unemployed	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Edward Cager Sr.		14. MOTHER'S MAIDEN NAME Ida Coatley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Thelma Cager		Address Same as # 2 (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency 54.5 DUE TO Congestive Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Congenital Heart disease (c) years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Brochaectasia Rt Lower Lb. Epilepsy			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton Owatkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON OWATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgely Selby		24. REC'D BY REGISTRAR SEP 14 '60	
ADDRESS 405 4th St Laurel		24b. REGISTRAR'S SIGNATURE William E. Farrow	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be re-used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

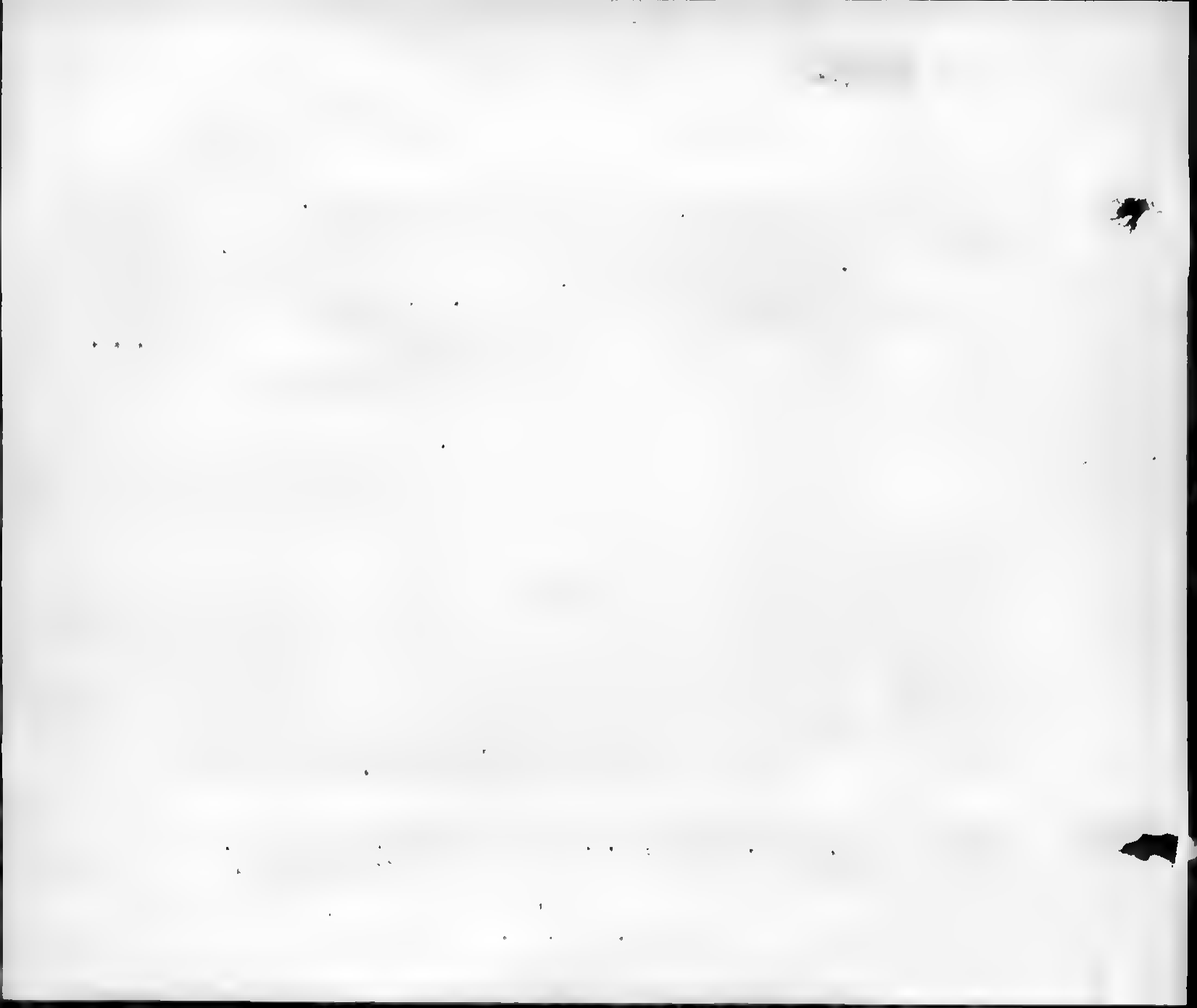
10587

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10571

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Day 4 Hr	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxen Hill, (Washington 20)		d. STREET ADDRESS 1 2509 Southern Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Carle		4. DATE OF DEATH Month Day Year Sept. 22, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1960
9. AGE (In years last birthday) - yrs		10. IF UNDER 1 YEAR Months Days Hours Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kenneth Robert Carle		14. MOTHER'S MAIDEN NAME Helen Catherine Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mother. Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 162.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) (c) Atitidian Prematurity			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 20, 1960 to Sept 22, 1960 , that (I) (we) last saw the deceased alive on Sept. 21, 1960 , and that death occurred at 3:10 a.m. from the causes and on the date stated above.			
22a. SIGNATURE John W. Perkins, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. John W. Perkins, M.D.		22d. ADDRESS 5301 Hamilton St. Hyattsville, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-30-60	
23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Maryland		23d. LOCATION (City, town or county) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		25a. REC'D BY REGISTRAR OCT 4 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Kline		25c. DATE OCT 4 '60	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10588

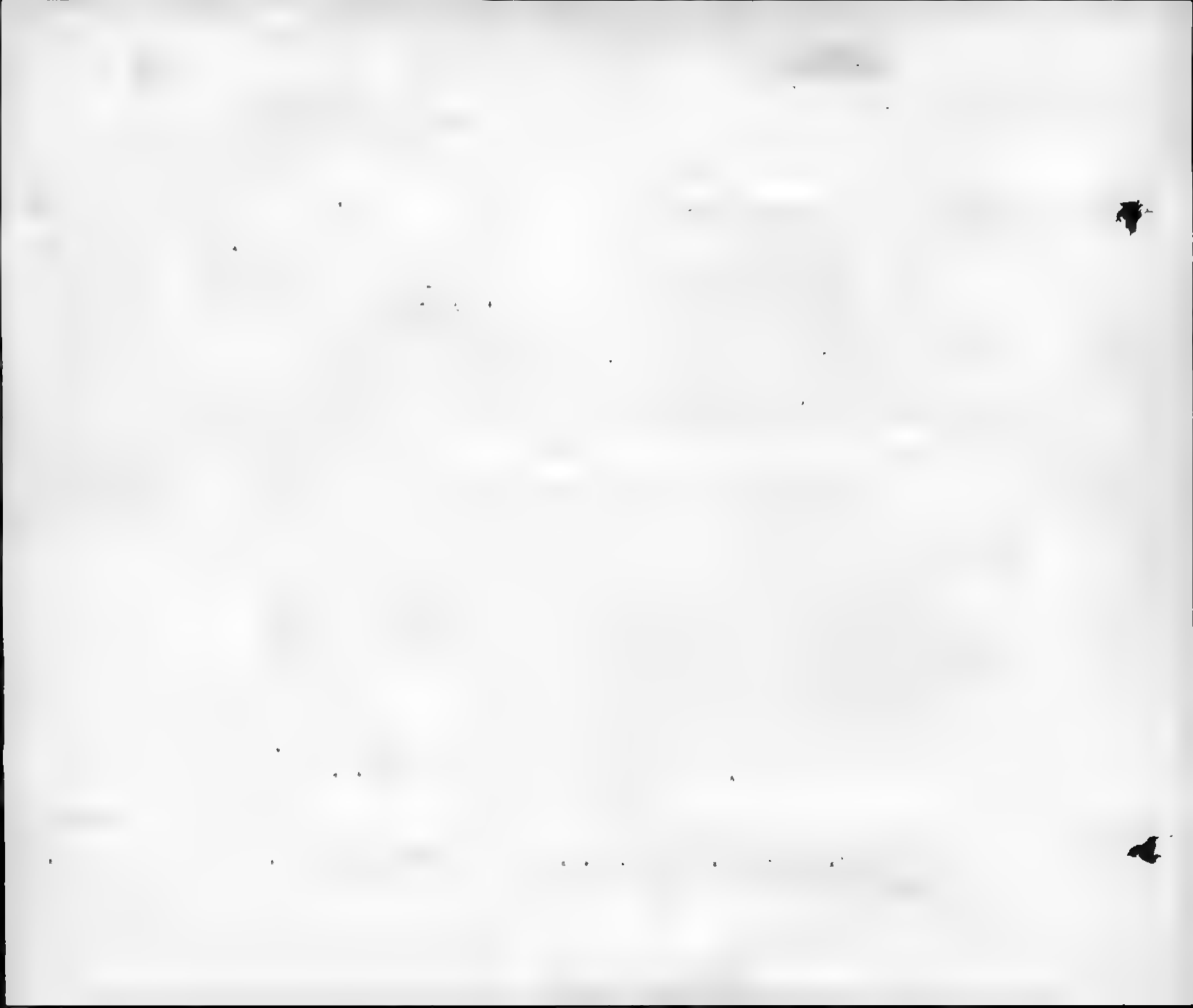
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1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 Mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS College Park 9806 49th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle A Last Carroll				4. DATE OF DEATH Month Sept. Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1876 Dec. 1, 1876	
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Bar tender		11. BIRTHPLACE (State or foreign country) Wash. D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Joseph S. Carroll				14. MOTHER'S MAIDEN NAME Mary Ellen Simms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 9806-4924		17. INFORMANT Marion Hartnell College Park, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic arteriosclerotic heart disease. INTERVAL BETWEEN ONSET AND DEATH Unknown							
260X DUE TO (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic arteriosclerotic gangrene of left foot							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 12 , 19 60 , to Sept. 8 , 19 60 , that (I) (we) last saw the deceased alive on Sept. 8 , 19 60 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Harold S. Tidler				22b. ADDRESS 8402 Fenton St. Silver Spring, Md.			
22c. PHYSICIAN'S NAME (Type) Dr. Harold S. Tidler, M.D.				22d. ADDRESS 8402 Fenton St. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-10-1960		23c. NAME OF CEMETERY OR CREMATORY Compassional		23d. LOCATION (City, town, or county) (State) Wash D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE R. J. Hattig				25a. REC'D BY REGISTRAR SEP 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	
25c. ADDRESS 131 17th St SE				25d. ADDRESS Wash D.C.			



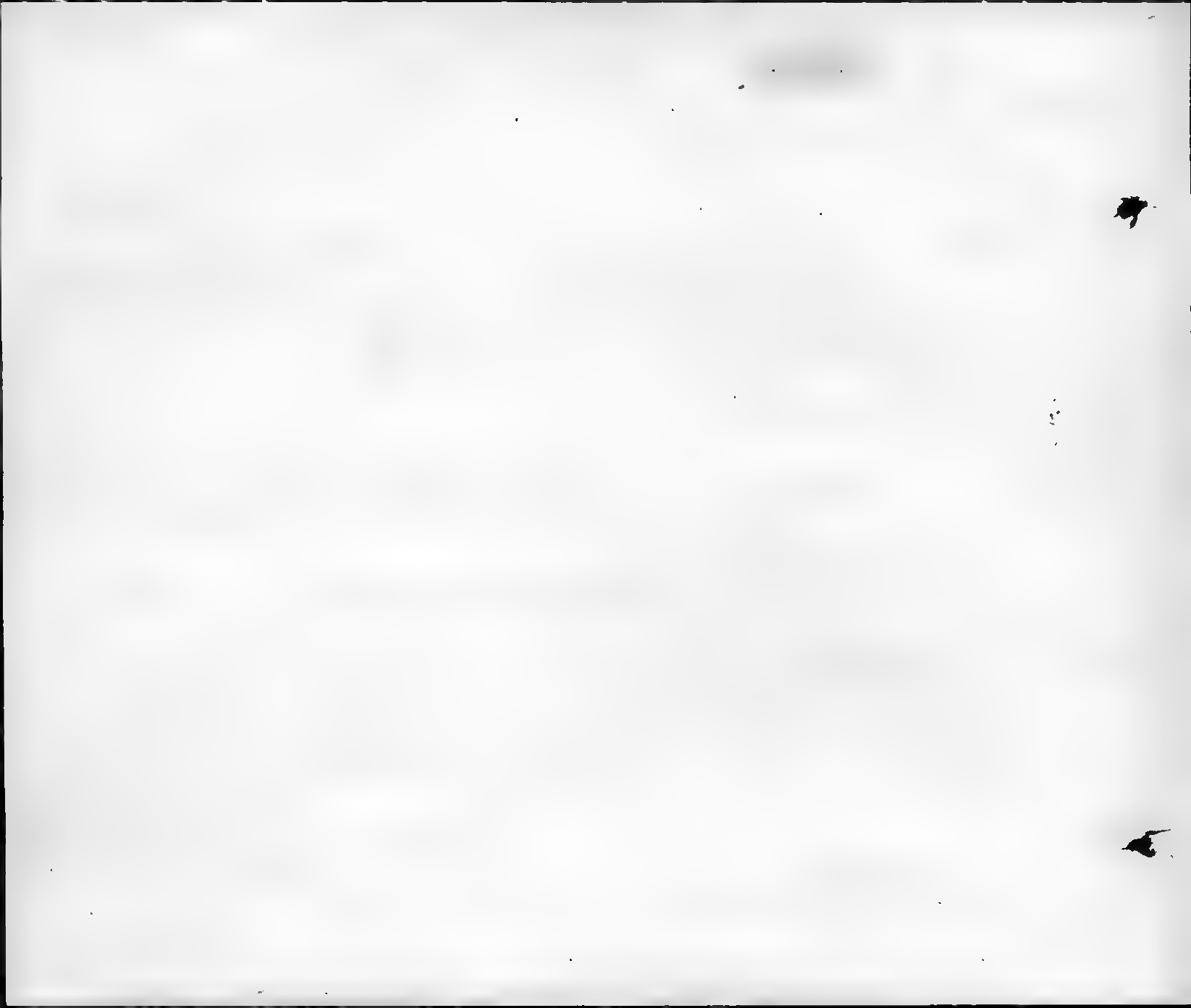
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10573

10647

1 PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carmody Hills</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carmody Hills</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>512 - 72nd place</i>		d. STREET ADDRESS <i>1512 - 72nd Place</i>	
3. NAME OF DECEASED (Type or print) <i>Minnie Estelle Carter</i>		4. DATE OF DEATH Month <i>9</i> Day <i>24</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-6-80</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William O Bear</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Moore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Samuel Lee Carter Carmody Hills</i>		Address <i>512 72nd Pl</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of uterus</i> DUE TO <i>with intraabdominal</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. <i>Metastasis</i> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9-1-1957</i> to <i>9-24-1960</i> ; that (I) (we) last saw the deceased alive on <i>9-24-1960</i> and that death occurred at <i>5P M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Peter Duus</i>		22b. DATE SIGNED <i>9-24-1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>PETER DUUS</i>		22d. ADDRESS <i>6124 Central Av. Capital Hgts Md.</i>	
23a. BURIAL CREMATION <i>Burial</i>		23b. DATE THEREOF <i>9/27/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Forestville, Episcopal</i>		23d. LOCATION (City, town, or county) (State) <i>Forestville, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		25a. REC'D BY REGISTRAR <i>SEP 27 '60</i>	
ADDRESS <i>Hyattsville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate and placed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10589

10574

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 days 14 1/2 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Radiant Valley d. STREET ADDRESS 6913-Randolph Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michael Middle Ciuffreda Last Ciuffreda				4. DATE OF DEATH Month September Day 7 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. Married NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH January 1, 1905	
9. AGE (in years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min 1		11. IF UNDER 24 HRS Months 5 Days 1 Hours 1 Min 1		12. IF UNDER 24 HRS Months 5 Days 1 Hours 1 Min 1	
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life, even if retired) Furniture Dealer		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Joseph Ciuffreda				14. MOTHER'S MAIDEN NAME Maria Piccerella			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes WW II		16. SOCIAL SECURITY NO WW II		17. INFORMANT Son Dom Ciuffreda Address 203 63rd St, Capitol Hgts, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thalassemia Major 392.2 DUE TO (b) 3 days Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1952 to 9/7 1960 that (I) (we) last saw the deceased alive on 9/2 1960 and that death occurred 11:50 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Frederick E. Musser		22b. ADDRESS 441 7th St N.E.		22c. PHYSICIAN'S NAME (Type) Dr. Frederick E. Musser		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town, or county) (State) Bladensburg, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Wm. See & Sons				25a. REC'D BY REGISTRAR SEP 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

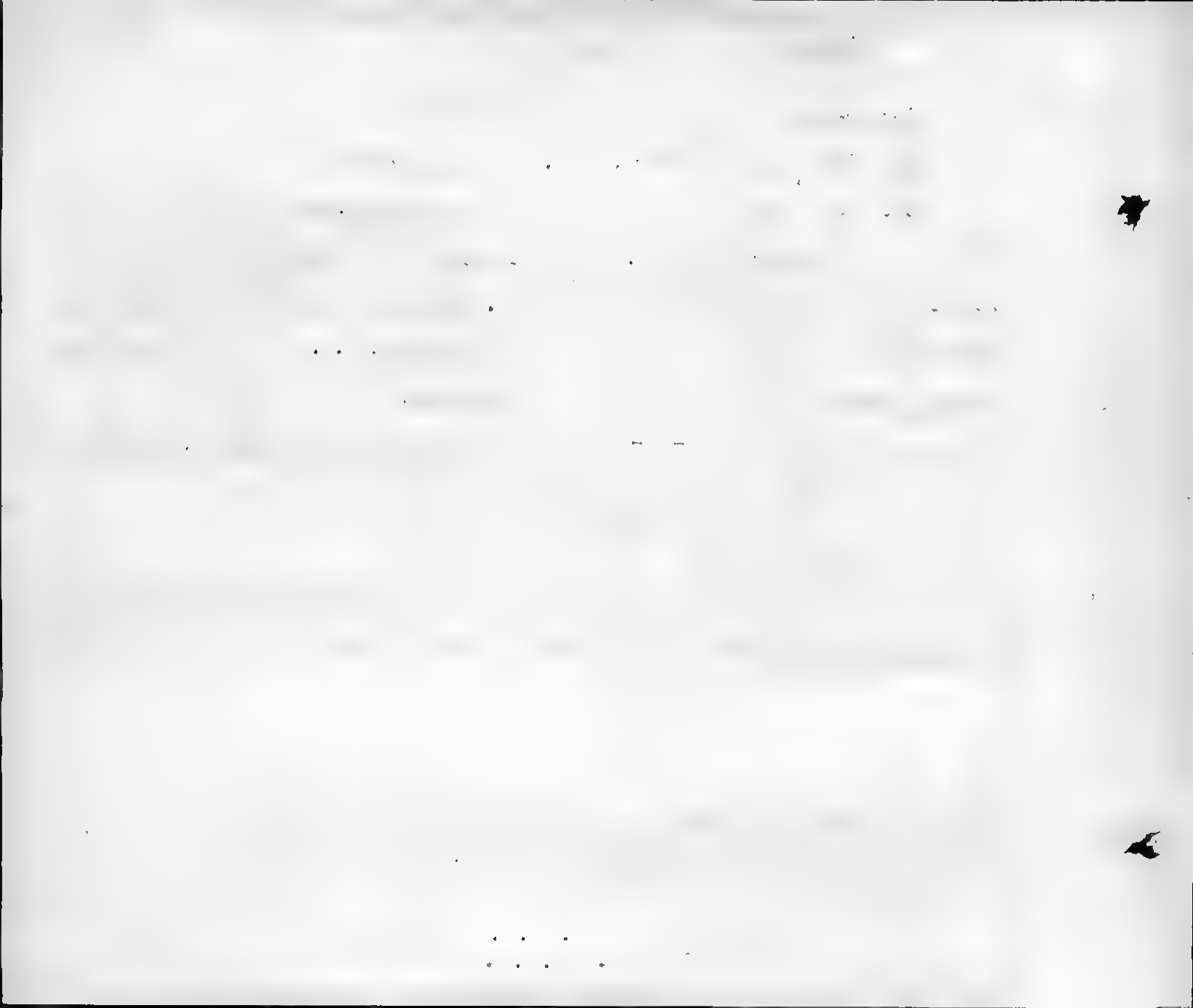
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10569

CERTIFICATE OF DEATH

Reg. Dist. No. 10575

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 years, 3 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) First Margaret Middle C. Last Clancy		4. DATE OF DEATH Month September Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Febr. 27, 1874
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) United States		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Michael Clancy		14. MOTHER'S MAIDEN NAME Nora Dunn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-01-3460	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis & myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) infarction DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8 , 19 58 , to Sept 27 , 19 60 , that I last saw the deceased alive on Sept 20 , 19 60 , and that death occurred at 8:45 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F Collins		ADDRESS (Street, city or town, state) 322 - H D N E	
PHYSICIAN'S NAME (Type) THOMAS F COLLINS, M.D.		DATE SIGNED 9-27-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-30-60	
22c. NAME OF CEMETERY OR CREMATORY HOLY ROOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 14th. St. N.W.	
24a. REC'D BY REGISTRAR Francis J. Collins		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

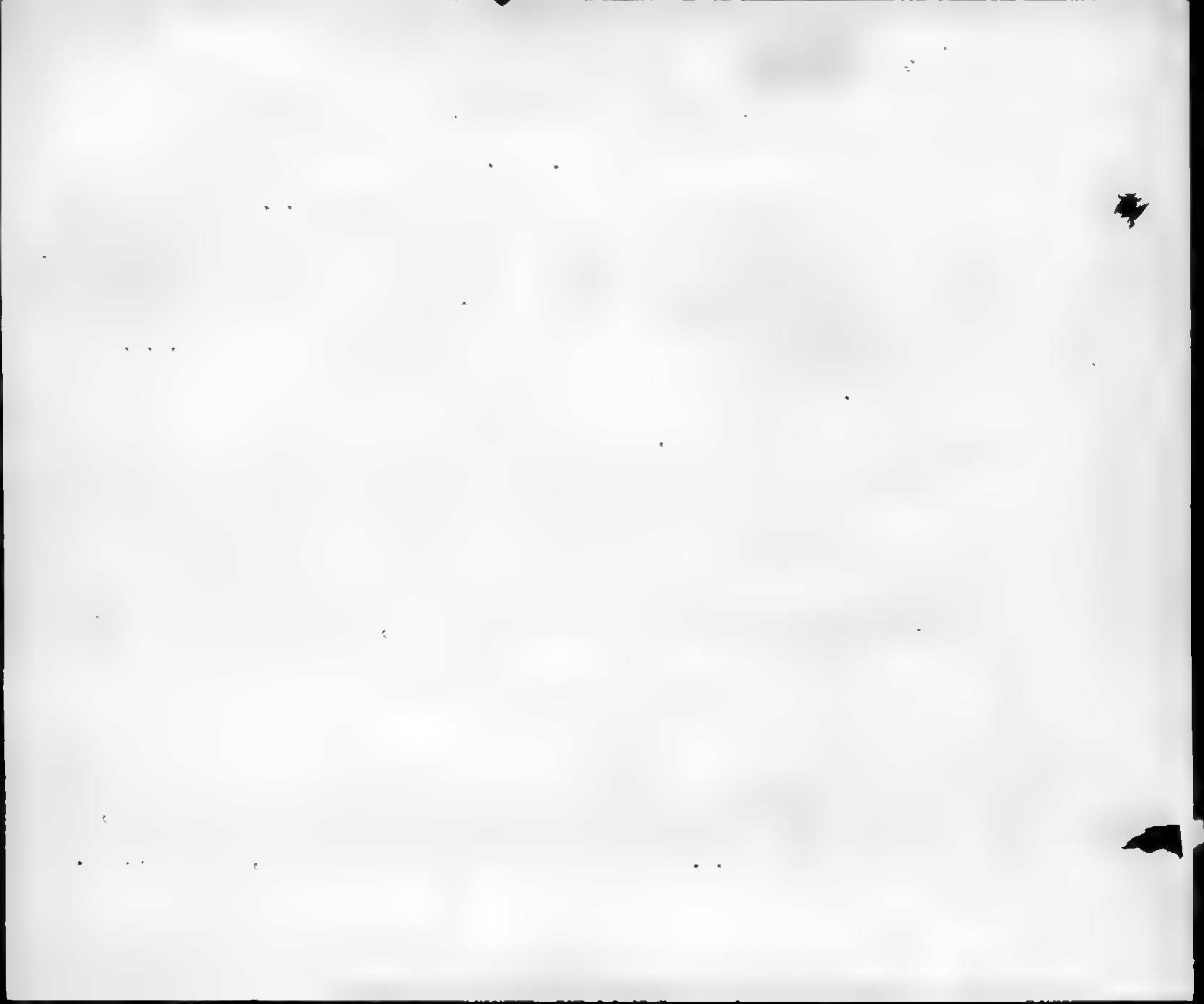
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15M 9/59

10648

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10576

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale		c. LENGTH OF STAY IN 1b 1 year, 8 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2651 16th Street, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last ETHEL PAULINE CLARK				4. DATE OF DEATH Month Day Year Sept 10 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 7, 1880		9. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Internal Revenue (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Atlanta, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Clark				14. MOTHER'S MAIDEN NAME Jennie Cooke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unk.		17. INFORMANT Person		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis; Pulmonary tuberculosis since 12/58; Tbc dorsal spine, D11 & D12 12/58							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 26 1959 to Sept 10 1960, that (I) (we) lost saw the deceased alive on Sept 10 1960, and that death occurred at 10:15 AM, from the causes and on the date stated above							
22a. SIGNATURE Moe Weiss		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE Sept 10, 1960		SIGNED	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 9-11-60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The J.A. Hines Co. 2901 14th St. N.W. Washington, D.C.				25a. REC'D BY REGISTRAR DATE SEP 15 '60		25b. REGISTRAR'S SIGNATURE Guthrie S. Kneass	



11672

Reg. Dist. No.

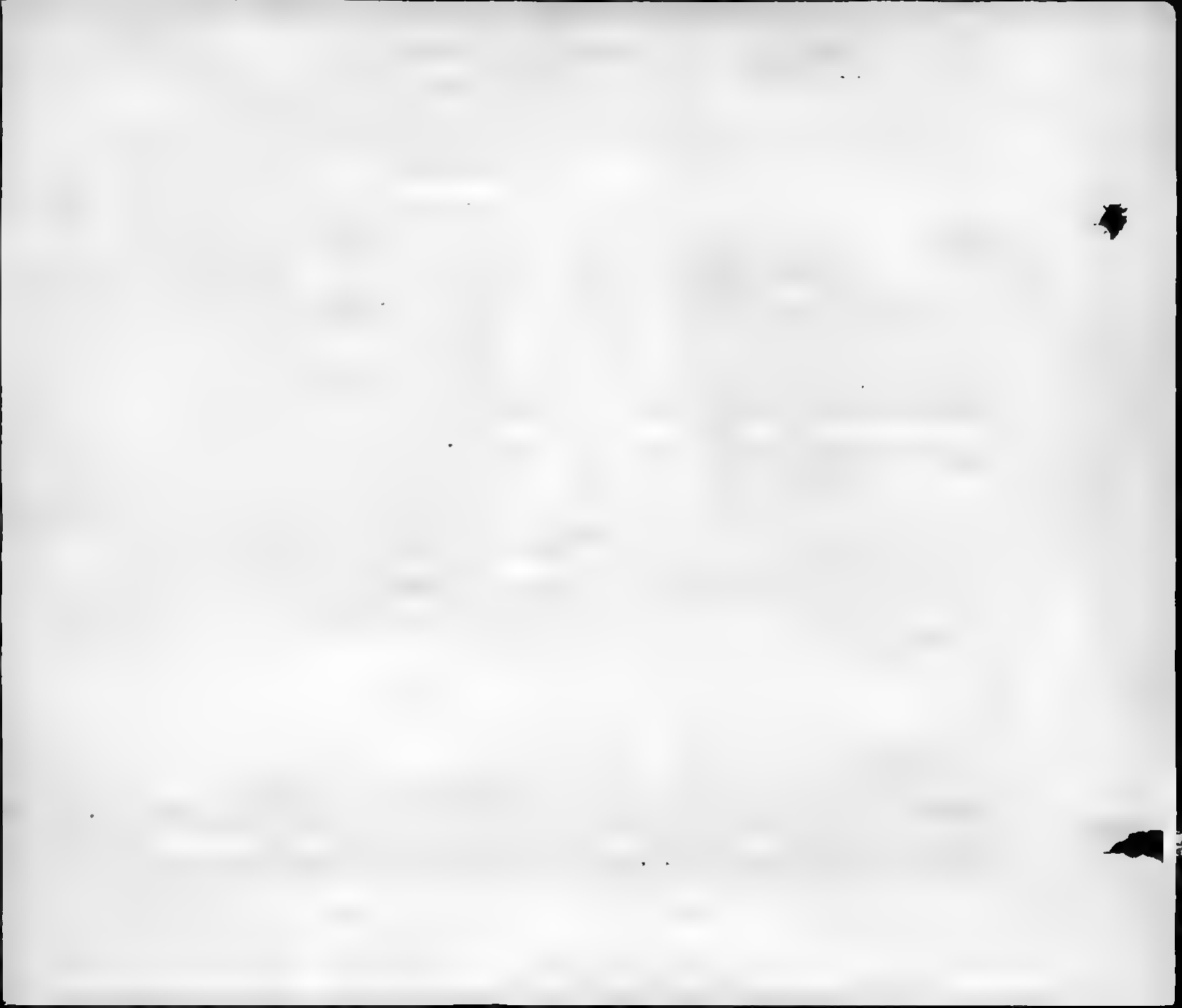
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 [4]
NEW OFF

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b Laurel d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Moore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Southern Pines d. STREET ADDRESS Box 974 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Clohossey		4. DATE OF DEATH Month September Day 30 Year 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 30, 1960	
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 25	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY?	
15. FATHER'S NAME Joseph Everett Clohossey		16. MOTHER'S MAIDEN NAME Thelma Clohossey	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		18. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
19. INFORMANT Joseph E. Clohossey (Father)		Address	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Immaturity of lungs 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Immaturity of lungs DUE TO (c) Immaturity of lungs		INTERVAL BETWEEN ONSET AND DEATH 1 hour + 25 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-30-1960 to 9-30-1960 , that I last saw the deceased alive on 9-30-1960 , and that death occurred at 10 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 305 Prince George Street, Laurel, Md. DATE SIGNED 10/3/60 ACTUAL SIGNATURE Idolo Pierandrei PHYSICIAN'S NAME (Type) Idolo Pierandrei, M.D. 305 Prince George Street, Laurel, Maryland			
22a. BURIAL, CREMATION, REMOVAL? (Specify) Buried		22b. DATE THEREOF 10/1/60	
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.		22d. LOCATION (City, town, or county) (State) Laurel Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Roper		24a. REC'D BY REGISTRAR 10/13/60	
ADDRESS Laurel, Md.		24b. REGISTRAR'S SIGNATURE John R. Roper	

208335 2XV 2



may be returned by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

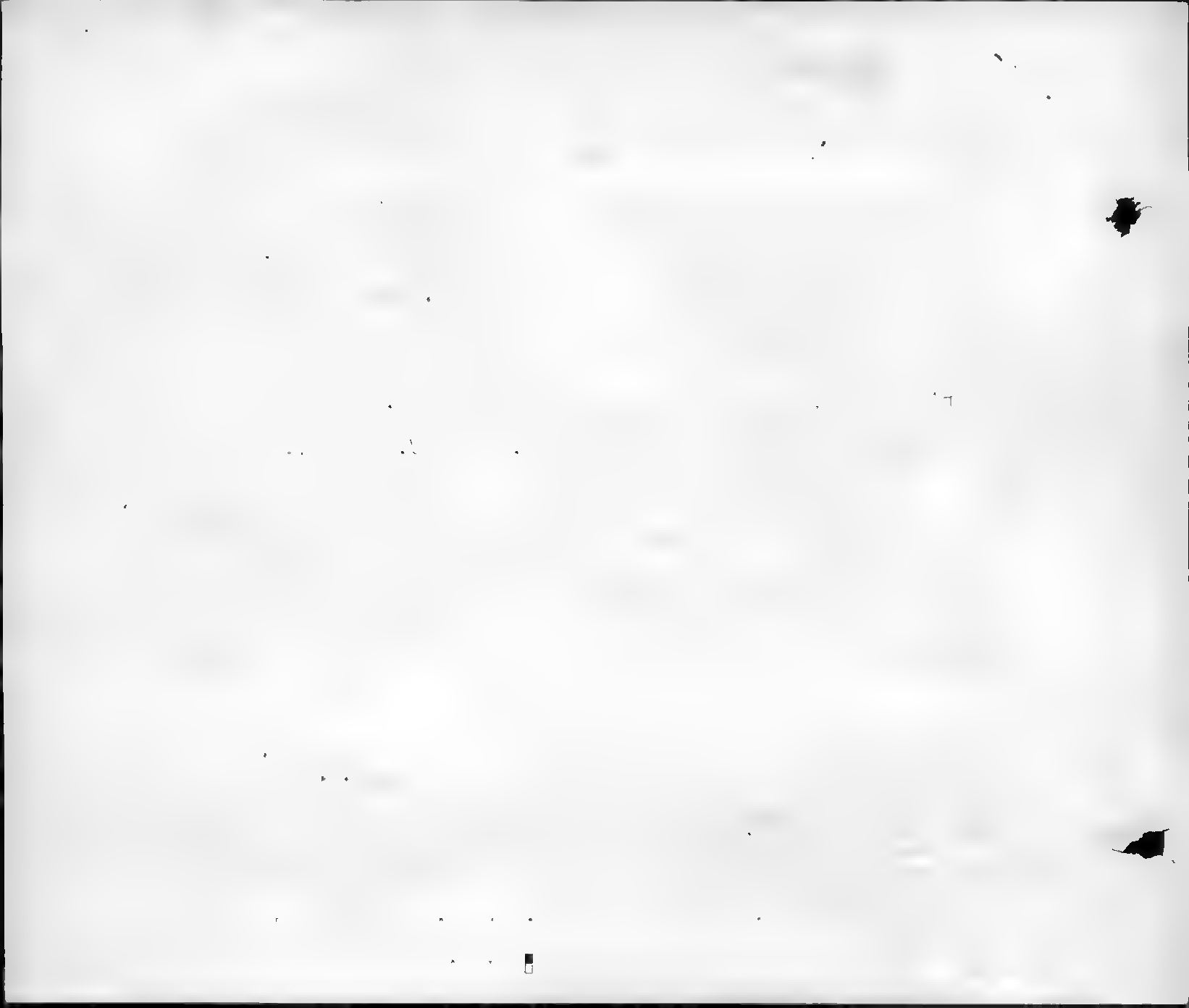
CERTIFICATE OF DEATH

10590

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

10578

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) First George Middle F Last Cornell		4. DATE OF DEATH Month Sept Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1922
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	11. IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abriel Cornell		14. MOTHER'S MAIDEN NAME Mamie E. Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO 214 18 8971	
17. INFORMANT Mrs. Ethel M. Cornell		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Epidermoid Ca left lung & metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 week (c) 4 mos		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 60 to Sept. 8 , 19 60 . that (I) (we) last saw the deceased alive on 19 60 and that death occurred at 12:40 P.M. on the causes and on the date stated above			
22a. SIGNATURE R. B. Basson		22b. DATE 9/8/60	
22c. PHYSICIAN'S NAME (Type) R. B. Basson		22d. ADDRESS Prince George Co. Hosp., Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 17th Sept. 1960	
23c. NAME OF CEMETERY OR CREMATORY Trinity Meth. Ch. Com.		23d. LOCATION (City, town, or county) (State) Odenton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE A. L. Longbottom		25a. REC'D BY REGISTRAR Glen Burris, Md.	
25b. REGISTRAR'S SIGNATURE Arthur L. Frank		DATE SEP 13 '60	



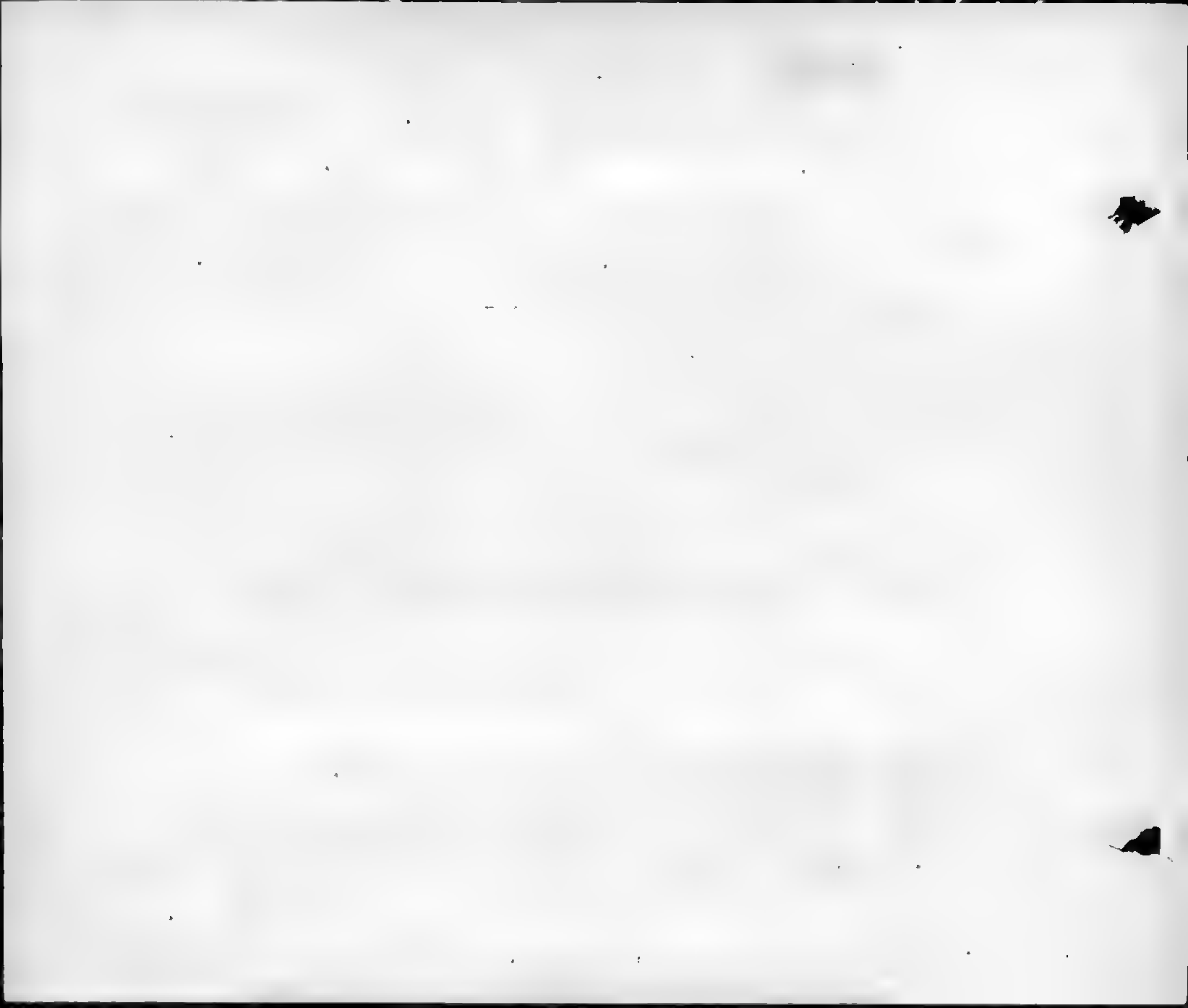
TO HOSPITAL & ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10579

10591

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 3425 Toledo Terrace			
3. NAME OF DECEASED (Type or print) First Mary Middle M. Last Cozlin				4. DATE OF DEATH Month Sept. Day 6 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-98		9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U S Treasury Dept				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles E Mc Namee				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Bladen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Robert L Cozlin Silver Springs, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction (coronary artery disease) DUE TO (b) Cardiac tamponade DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1959 to 9-6-60 that (I) (we) last saw the deceased alive on 9-5-60 and that death occurred at 8:25 AM the causes and on the date stated above							
22a. SIGNATURE Robert L Cozlin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-6-60	
22c. PHYSICIAN'S NAME (Type) Dr. Fleischer				22d. ADDRESS 5432 QUEENSCHAPEL RD, Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/10/60		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10580

10592

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 26 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 4106 Cottage Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruby Middle S Last Davis			4. DATE OF DEATH Month Sept. Day 9 Year 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12- 22-06	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) General Supplies Officer U.S. Government				10b. KIND OF BUSINESS OR INDUSTRY navy Dept.		11. BIRTHPLACE (State and country) Bavard, N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William Faulkner				14. MOTHER'S MAIDEN NAME Flora Goodson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Betty Weaver Address Daughter 9014 50th Place, College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma 2osis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Adeno-carcinoma Rt. Breast DUE TO (c) —							
INTERVAL BETWEEN ONSET AND DEATH 5 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Apr. 20, 1960 to Sept. 9, 1960 , that (I) (we) last saw the deceased alive on Sept. 9, 1960 , and that death occurred at 8:30 A.M. the causes and on the date stated above							
22a. SIGNATURE Charles C. Hageage M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Chas. Hageage, M.D.				22d. ADDRESS 3308 Perry St. Mt. Rainier, Md.			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland, Ch. Geo. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home ADDRESS Mt. Rainier, Md.				25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10581**

10593

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLCREST HEIGHTS		d. STREET ADDRESS 5105 28th PARKWAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE'S GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle OLLIE Last De MARR				4. DATE OF DEATH Month SEPT Day 23 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-44		9. AGE (In years last birthday) 16 yrs.	IF UNDER 1 YEAR Months 1 Days 18	IF UNDER 24 HRS. Hours 1 Min 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS P. De MARR				14. MOTHER'S MAIDEN NAME LETTIE V. RIPLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT LETTIE V. De MARR Address 5105 PARKWAY HILLCREST HT. MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral laceration + Contusion 824X DUE TO Conditions, if any, which gave rise to immediate cause (b) Basilar Fracture of skull inst (a), stating the underlying cause last. DUE TO Fractured ribs (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident - Thrown from car					
20c. TIME OF INJURY Hour 11 a.m. Month, Day, Year 9/28/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Accokeek, Pa (County) Prince Georges (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dayton O WATKINS		EXAMINER'S NAME (Type) DAYTON O WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-24-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 9/28/60		22c. NAME OF CEMETERY OR CREMATORY Trinity Memorial		22d. LOCATION (City, town, or county) (State) Accokeek, Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Connelley				ADDRESS 277 11th St SE		24a. REC'D BY REGISTRAR SEP 28 '60	
				24b. REGISTRAR'S SIGNATURE William J. Connelley			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME
SM 9/53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10649 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10582

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		c. LENGTH OF STAY IN 15 <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		d. STREET ADDRESS <u>R.F.D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Alexander Dent</u>				4. DATE OF DEATH <u>Sept. 5</u> 19 <u>60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1960</u>		9. AGE (in years last birthday) yrs. <u>1</u> Months <u>7</u> Days <u>27</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Seafield Essex?</u>				14. MOTHER'S MAIDEN NAME <u>Alice Dent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Alice Dent Upper Marlboro</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491X</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none of note</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>PAUL C VAN NATTA act</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Sept 5 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Flower Lane</u>		22d. LOCATION (City, town, or county) (State) <u>Torrestville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>				ADDRESS <u>4339 Hunt Pl., N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>	

Washington, D.C.



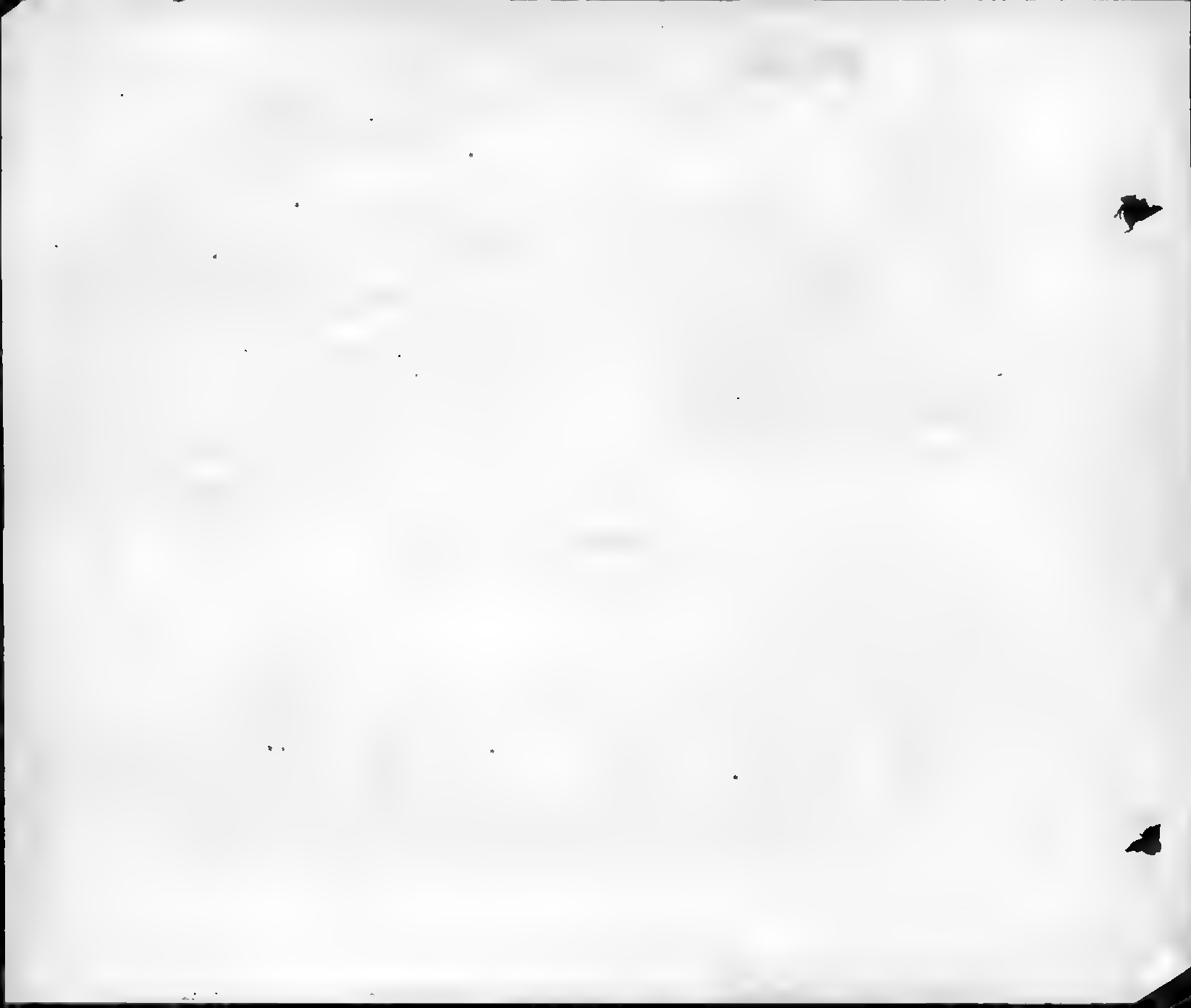
10594

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10583

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 18 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville d. STREET ADDRESS 2005 Oglethorpe St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Louis F Dilger				4. DATE OF DEATH Month Day Year Sept. 1 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1881	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		11. BIRTHPLACE (State or foreign country) Troy, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hubert Dilger				14. MOTHER'S MAIDEN NAME Elizabeth Fiedemann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) 21732-1858				16. SOCIAL SECURITY NO. 21732-1858			
17. INFORMANT Fanny M. Dilger, wife				Address about			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition Clinical DUE TO (b) Hepaticoma Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 13 1960 to Sept. 1 1960 , that (I) (we) last saw the deceased alive on Aug. 31 1960 , and that death occurred at 2:55 AM from the causes and on the date stated above.							
22a. SIGNATURE R. S. Fleischer				22b. DATE SIGNED 9-1-60			
22c. PHYSICIAN'S NAME (Type) R. S. FLEISCHER				22d. ADDRESS 1432 QUEENS CHAPEL RD. HYATTSVILLE			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		9/3/60		mt. Olivet		Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home				ADDRESS mt. Rainier Md.		25a. RECEIVED BY REGISTRAR SEP 6 1960	
						25b. REGISTRAR'S SIGNATURE Arthur S. Prince	



10650

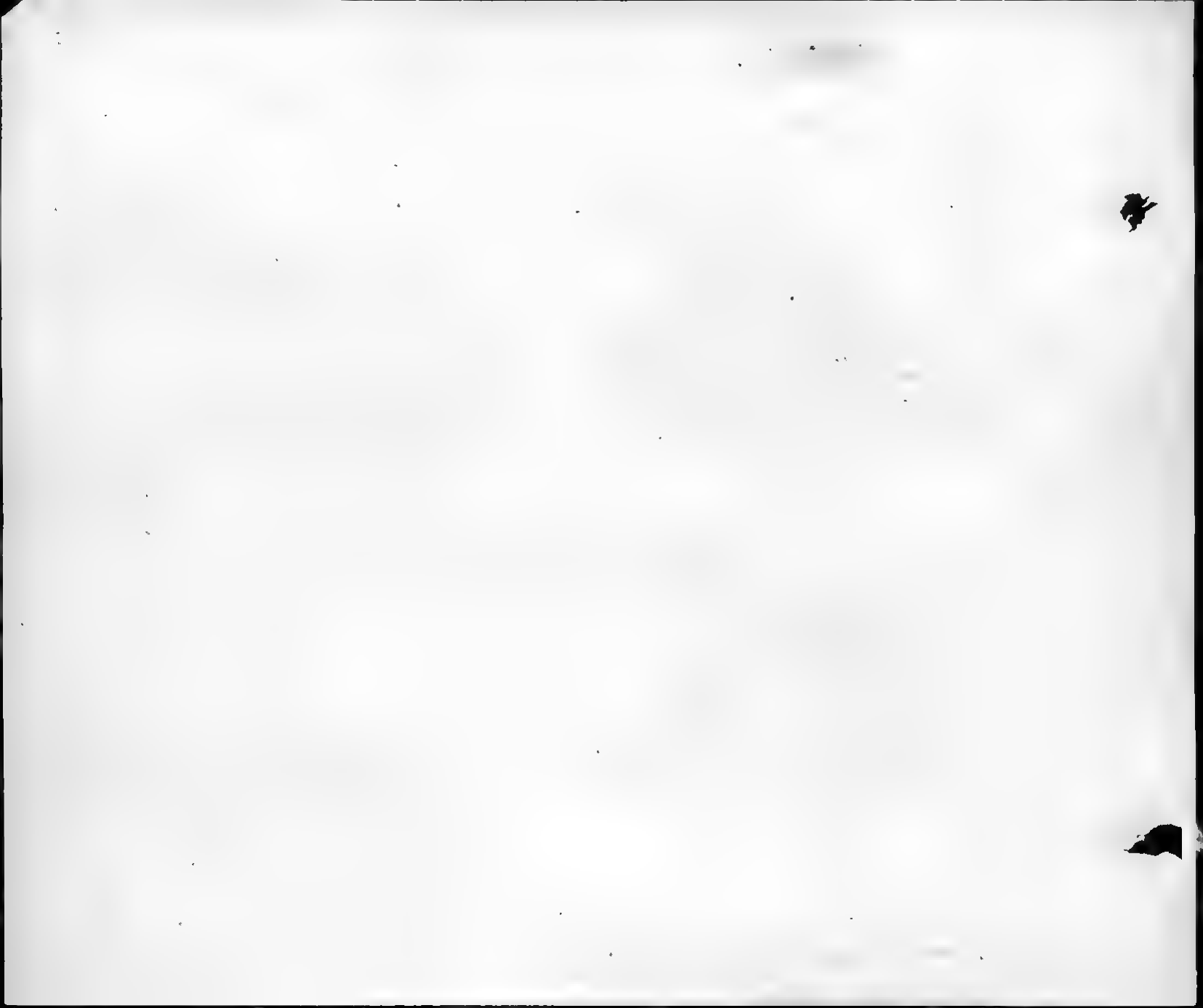
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Adelphi		c. LENGTH OF STAY IN 1b 10 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) Saint Branch Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Violetta (none) Donald		4. DATE OF DEATH Month Day Year September 28 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1882 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting clerk		10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue Pennsylvania	
13. FATHER'S NAME Alfred Halstead		14. MOTHER'S MAIDEN NAME Mary Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1) DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Congestive Heart Failure (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 Day 3 wks Several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1960, to 9-28, 1960, that I last saw the deceased alive on 9-27, 1960, and that death occurred at 4:20 AM, from the causes and on the date stated above * Seen by Father - Dr M.R. Quinnam			
ACTUAL SIGNATURE Stuart L. Nelson		DATE SIGNED 9-28-60	
PHYSICIAN'S NAME (Type) Stuart L. Nelson		ADDRESS (Street, city or town, state) Tokoma Park ... Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR 0813 60 DATE	
		24b. REGISTRAR'S SIGNATURE Vincent L. Piana	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

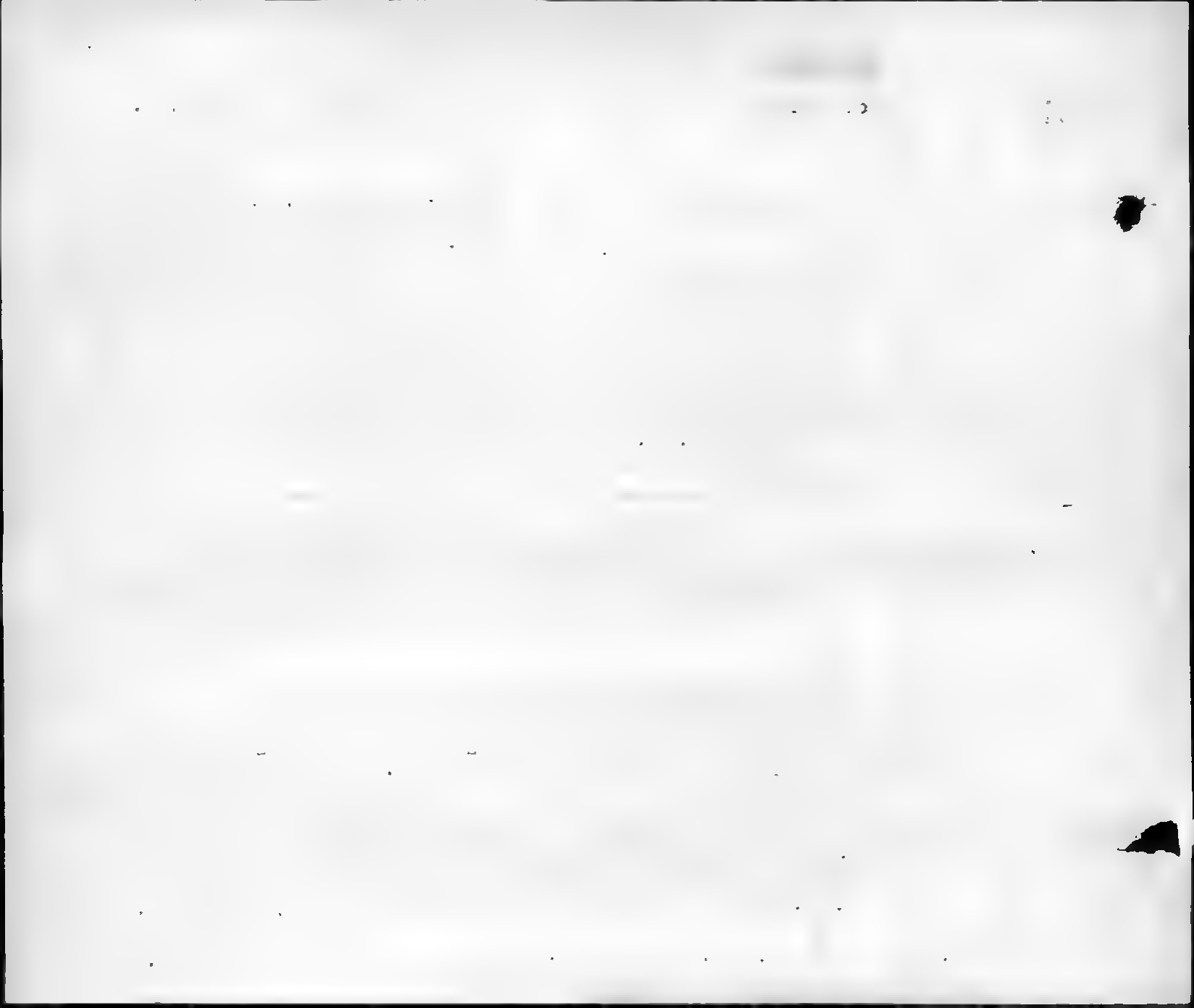
CERTIFICATE OF DEATH

10585

10595

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Washington b. COUNTY Dist. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, 27	
		f. STREET ADDRESS 6515 Buchanaan St., N.E.	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		4. DATE OF DEATH Month Sept. Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1881
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 15 Min 00	11. IF UNDER 24 HRS Hours 15 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Effinger		14. MOTHER'S MAIDEN NAME Margaret Ziegler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I		16. SOCIAL SECURITY NO. 577.10.2446	
17. INFORMANT Margaret. Timms. Lewes. Delaware		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Atherosclerosis DUE TO (b) with myocardial degeneration DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis with compression vertebral fractures		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-19-60 to 9-23-60 , 19 60 , that (I) (we) last saw the deceased alive on 9-23 1960 , and that death occurred at 2P M. from the causes and on the date stated above.			
22a. SIGNATURE William Brainin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. William Brainin		22d. ADDRESS 6124 Central Avenue	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE THEREOF 9.26.1960	23c. NAME OF CEMETERY OR CREMATORY Addison Chapel Cemetery	23d. LOCATION (City, town, or county) (State) Seap. Pleasant. Md
24. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home. 300. 4th. st N E. Wash.		25a. REC'D BY REGISTRAR DATE SEP 27 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles P. Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



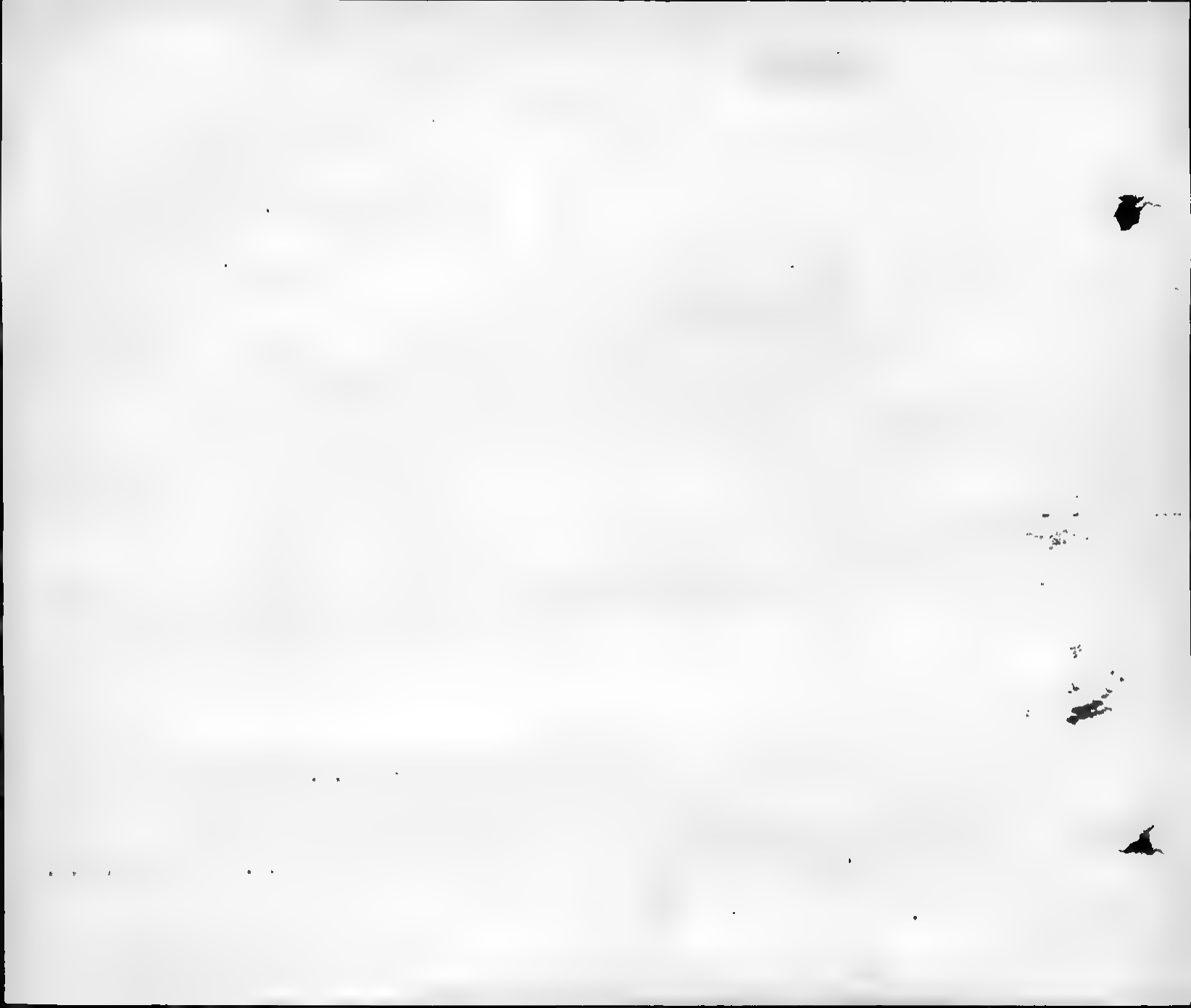
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10586

10596

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b 2 1/2 days				d. STREET ADDRESS 9307 Glennville Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Jane Middle Fee Last Ree		4. DATE OF DEATH		Month Sept. Day 22 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/33	9. AGE (In years last birthday) 26 yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Brook Smith				14. MOTHER'S MAIDEN NAME Elizabeth Rush			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO Elizabeth Smith			
17. INFORMANT Elizabeth Smith				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 672X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Shock DUE TO (c) Post partum vaginal wall hematoma						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from February 19 60 to Sept 20 19 60 , that (I) (we) saw the deceased alive on 9/22 19 60 and that death occurred at 10:15 a.m. from causes and on the date stated above							
22a. SIGNATURE Dr. John Francis Warren				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. John Francis Warren				22d. ADDRESS 2015 R Street, N.W. Washington, D.C.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial Sept 25/1960 Prospect Hill Potomac Royal		Sept 25/1960		Prospect Hill Potomac Royal		Montgomery Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. D. Davis				25a. REC'D BY REGISTRAR SEP 26 '60		25b. REGISTRAR'S SIGNATURE	
Hyattsville, Md.							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 FilmG-71 9-14-60 et

10651

CERTIFICATE OF DEATH

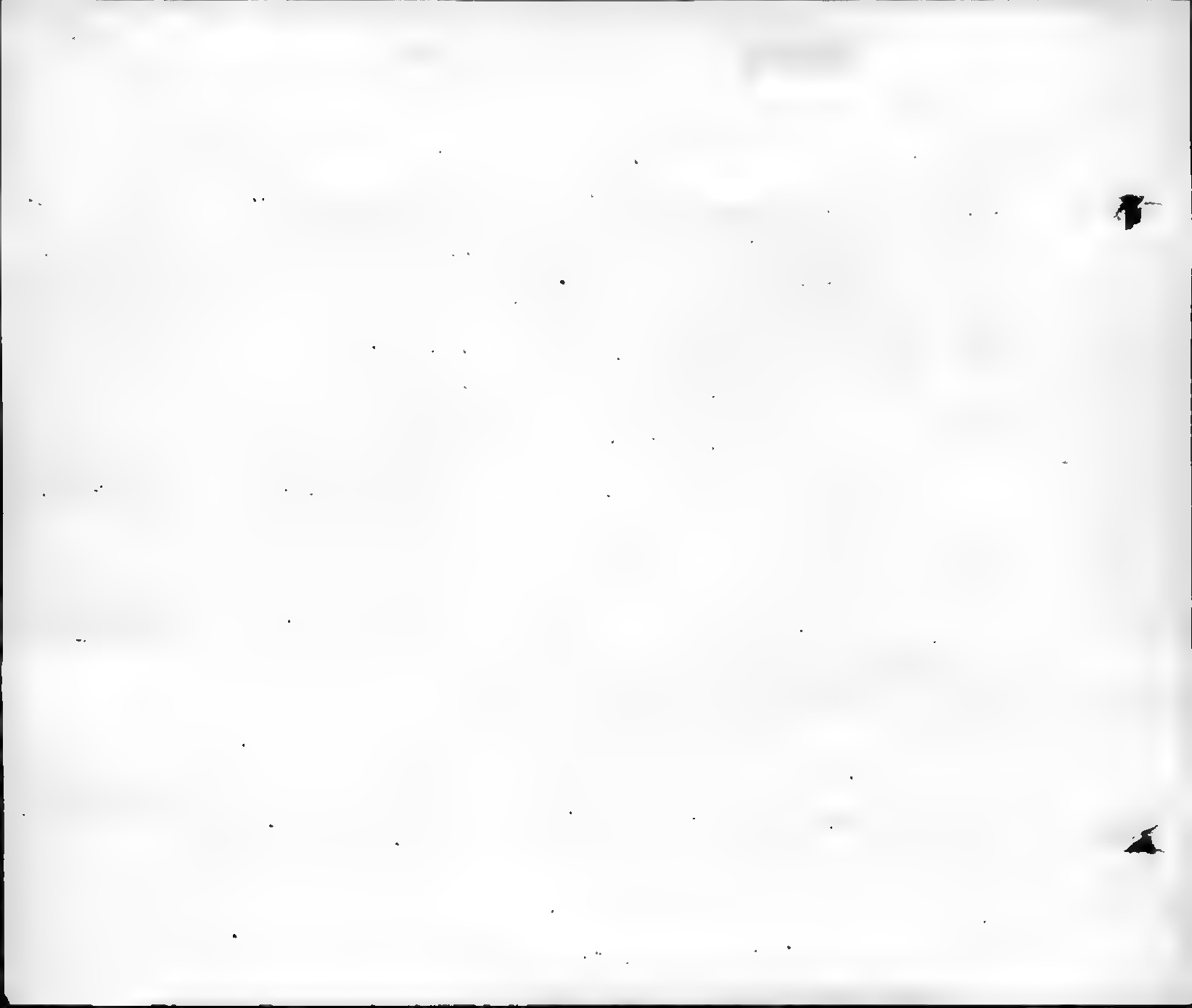
Reg. Dist. No.

10587

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>P. Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>				c. LENGTH OF STAY IN 1b <i>19 dys</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deer Park Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>So Maryland Hospital Ctr</i>				d. STREET ADDRESS <i>6223 Raleigh Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ULMAN K. FITZHUGH</i>				4. DATE OF DEATH Month Day Year <i>SEP 9 1960</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 18, 1884</i>	
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done, including most of working life, even if retired) <i>Plant Manager</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Equipmt</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>JOHN FITZHUGH</i>				14. MOTHER'S MAIDEN NAME <i>PEGGY</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <i>224 125807</i>			
17. INFORMANT <i>Maryln Otto</i>				Address <i>Deer Pk Hgts, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>420.11</i> DUE TO (b) <i>420.11</i> DUE TO (c) <i>420.11</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <i>19 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis & atherosclerosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>7</i> 19 <i>57</i> to <i>9/9</i> 19 <i>60</i> , that I last saw the deceased alive on <i>9/9</i> 19 <i>60</i> , and that death occurred at <i>12:40</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lewis PARKER</i>				DATE SIGNED <i>9-9-60</i>			
PHYSICIAN'S NAME (Type) <i>Lewis PARKER</i>				ADDRESS (Street, city or town, state) <i>5241 St. Pauline St. Md.</i>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-13-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Johnstown Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Johnstown, Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros 1661 Spode Road</i>				24. REC'D BY REGISTRAR <i>SEP 13 '60</i>		25. REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10638

10588

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>37 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> d. STREET ADDRESS <u>1 Navahoe St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Agnes</u> First <u>Forrest</u> Middle Last 4. DATE OF DEATH <u>9-19-</u> Month Day Year <u>1960</u>				5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-2-1878</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alison Walls</u>				14. MOTHER'S MAIDEN NAME <u>Susan West</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Hospital Record</u>				17. INFORMANT <u>Daughter Alberta Brooks</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia and</u> <u>151X</u> DUE TO (b) <u>Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) <u>Carcinoma of Stomach</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 12, 1960</u> to <u>Sep 17, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sep 18, 1960</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above									
22a. SIGNATURE <u>Theodore Zegarra, M.D.</u> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Theodore Zegarra, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9-23-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nat Harmay Park</u>		23d. LOCATION (City, town, or county) (State) <u>Shiriff Rd Egt Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>H5 Washington 4925 Dean Ave NE</u>				25a. REC'D BY REGISTRAR <u>DATE SEP 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Hume</u>			



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

10631

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10589

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston Md				c. LENGTH OF STAY IN 1b 9 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5114 Crittenden Street				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston Md.			
f. STREET ADDRESS 5114 Crittenden Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Benjamin Last Fowler				4. DATE OF DEATH Month September Day 25 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 28, 1868	
9. AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Baker			
13. FATHER'S NAME Alvin Perry Fowler				14. MOTHER'S MAIDEN NAME Sarah Gibbs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Beulah Lee Fowler				Address Edmonston Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 24, 1960 to Sept 24, 1960 that (I) (we) last saw the deceased alive on Sept 24, 1960, and that death occurred at M, from the causes and on the date stated above							
22a. SIGNATURE B. Rosenberg				22b. DATE SIGNED Sept 25, 1960			
22c. PHYSICIAN'S NAME (Type) B Rosenberg				22d. ADDRESS 1210 Chillum Manor Rd.			
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial				23b. DATE THEREOF Sept 27, 1960			
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE SEP 28 60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)

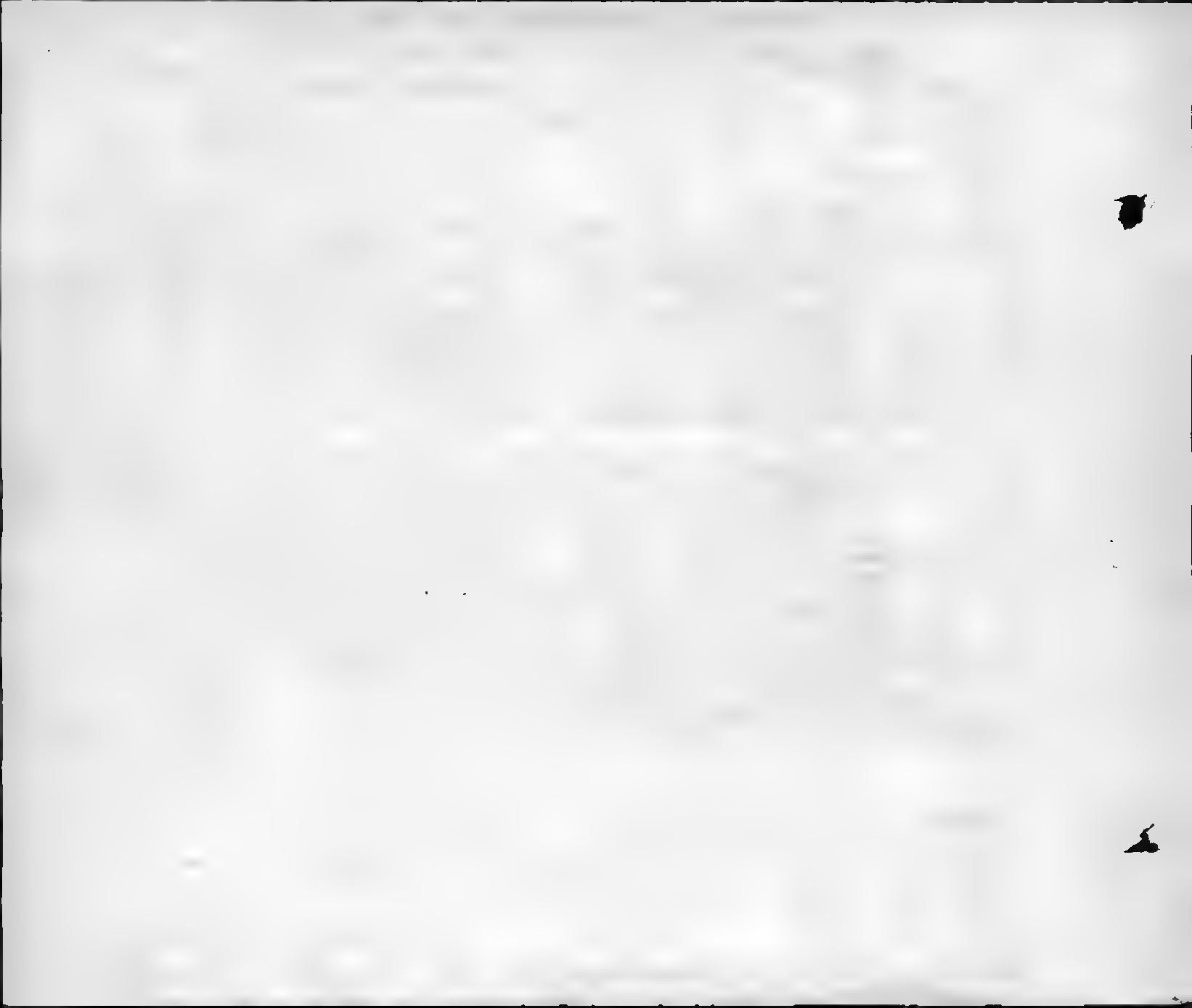
SM 9/55

News

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Item 4b. File # 272-10-60 and 10597											
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 10590											
1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr Geo</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chure</i>				c. LENGTH OF STAY IN 1b <i>DOH</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forest Heights 1E</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Geo General</i>				d. STREET ADDRESS <i>283 Cree dr</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>C HESTER ALBERT FRANCIS</i>				4. DATE OF DEATH Month Day Year <i>Sept 29 1960</i>							
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 11 1960</i>		9. AGE (In years last birthday) yrs. <i>7</i> Months <i>19</i> Days <i>19</i> Hours <i>Min.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>				11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert A AKA L Francis</i>				14. MOTHER'S MAIDEN NAME <i>Dorothy L Kruger</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>RA FRANCIS</i>				17. ADDRESS Address <i>283 Cree Dr Forest Heights Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> <i>129.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Subject fell from crib into a diaper pail which held water.</i>											
20c. TIME OF INJURY Month, Day, Year <i>615 a.m. 9-29-60</i>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Forest Heights Md</i>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dayton Watkins</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <i>DAYTONO WATKINS</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<i>9-29-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>Oct 4-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sunset Memorial Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Montevideo Minnesota</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Seniors Bros</i>				ADDRESS <i>1661-600 Hope Rd SE Wash DC</i>		24a. REGD BY REGISTRAR <i>Oct 3 60</i>		24b. REGISTRAR'S SIGNATURE <i>Walter S. Frank</i>			

9VVVVVVXVV



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10594

10598

1. PLACE OF DEATH a. COUNTY Prince Geo MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pr Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesney		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Brentwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General				d. STREET ADDRESS 4541 BANNER			
3. NAME OF DECEASED (Type or print) First Middle Last HANNAH GILMORE				4. DATE OF DEATH Month Day Year Sept 19 1960			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH untersoon	
9. AGE (In years last birthday) 82 years		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A Johnson				14. MOTHER'S MAIDEN NAME Carolyn (-Johnson)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Laurie Evans Brentwood			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dehydration, Acidosis</u> DUE TO <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 years</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton O. Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-20-60</u>			
22a. BURIAL-CREATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Jenkins</u>				ADDRESS <u>4804 14th Ave. NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be emitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and must be event, within 72 hours after death.

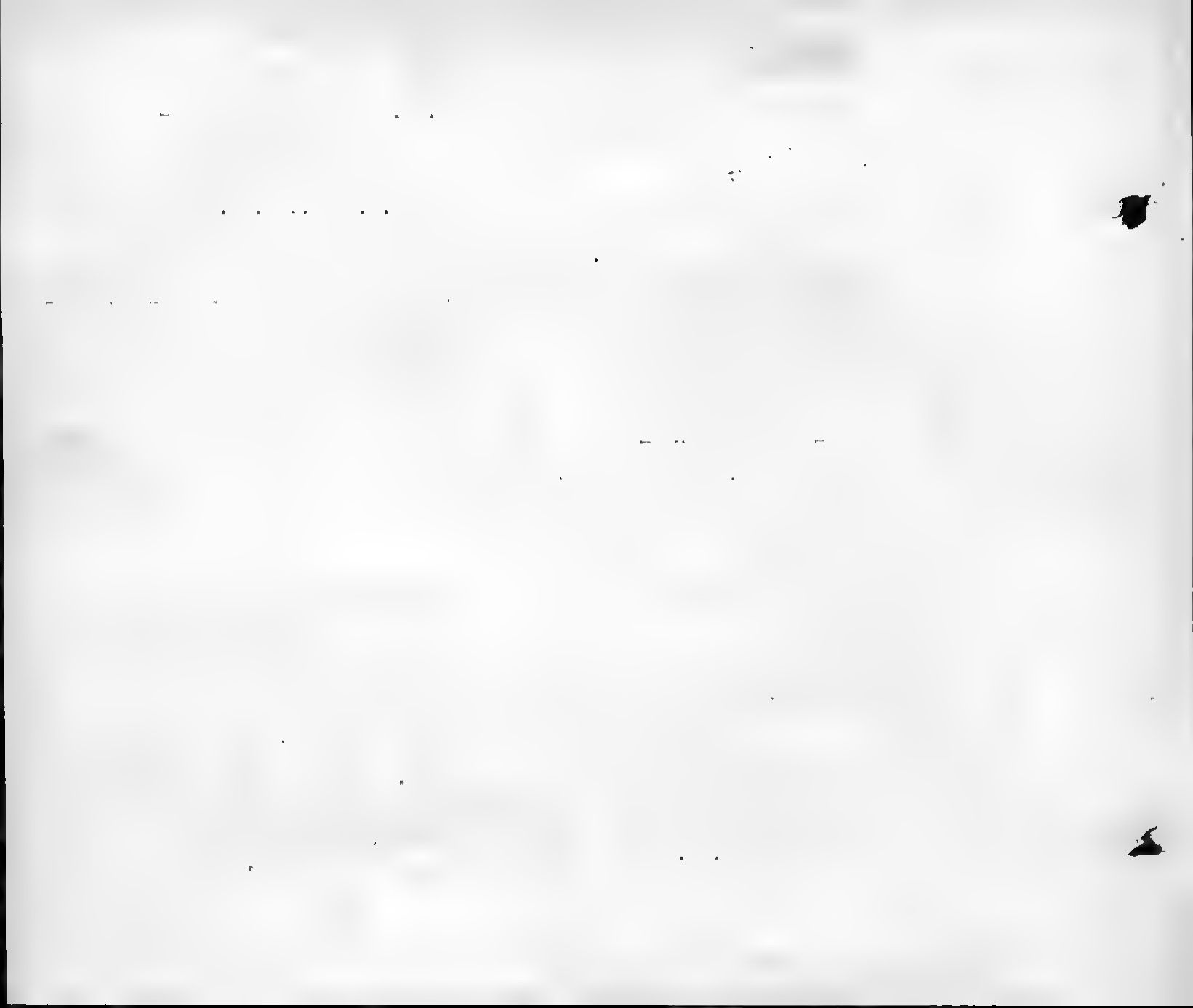
VR AIS (4)
ISM 9/59

10652

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10592

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN U.S. 1 month and 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 115 N.Y. Ave., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Howard D. Goldston				4. DATE OF DEATH Month Day Year 9 19 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/14	9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Goldston				14. MOTHER'S MAIDEN NAME Goldie Matthews Goldston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unknown		16. SOCIAL SECURITY NO. 241-12-8813		17. INFORMANT Decedent Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of urinary bladder 181.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 7/27/60, 19 to 9/19/60, 19, that (I) (we) last saw the deceased alive on 9/19/60, 19, and that death occurred at 2:35 M, from the causes and on the date stated above. 22a. SIGNATURE Moe Weiss, M. D. M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9/19/60 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.							
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF 9-23-60		23c. NAME OF CEMETERY OR CREMATORY St Paul		23d. LOCATION (City, town or county) (State) Cummrock N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE North Funeral Home W. J. Hunter		ADDRESS Sanford, N.C.		25a. REC'D BY REGISTRAR SEP 23 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

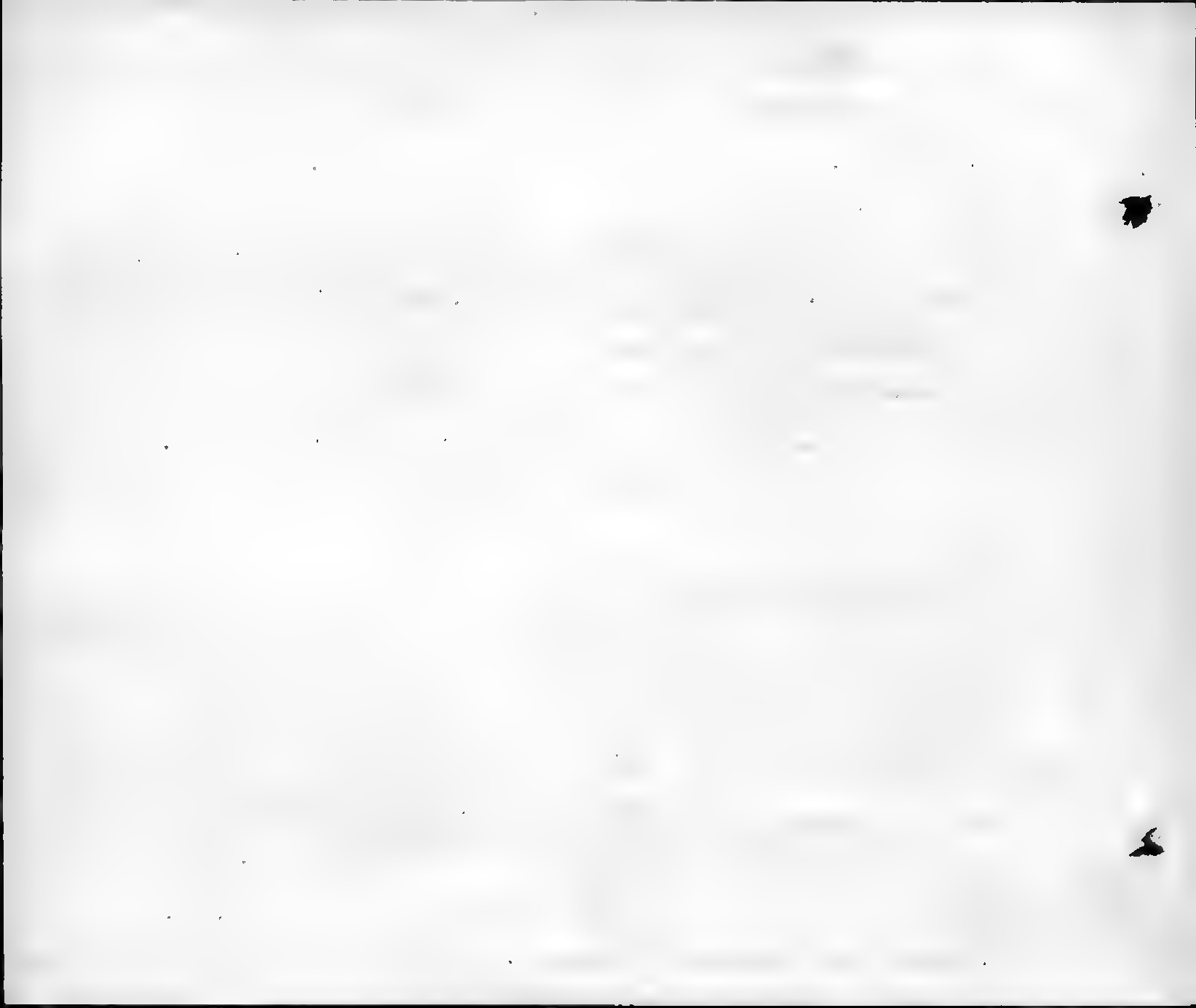
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10570

CERTIFICATE OF DEATH

Reg. Dist. No. 10593

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md		c. LENGTH OF STAY IN 1b 23 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4300 Queensbury Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md. d. STREET ADDRESS 4300 Queensbury Road	
3. NAME OF DECEASED (Type or print) First Middle Last Ethel Babette Greaves		4. DATE OF DEATH Month Day Year September 14, 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1885
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Woellner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Norma Greaves Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>sarcoma of T. bone</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 15 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 15</u> 19 <u>60</u> to <u>Sept 15</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 15</u> 19 <u>60</u> , and that death occurred at <u>6:00 p.m.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED 9/16/60	
ACTUAL SIGNATURE Leonard Hays		M.D. Hyattsville Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE SEP 19 '60		24b. REGISTRAR'S SIGNATURE Charles L. Hume	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be required by the hospital or attending physician to sign this certificate. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10599

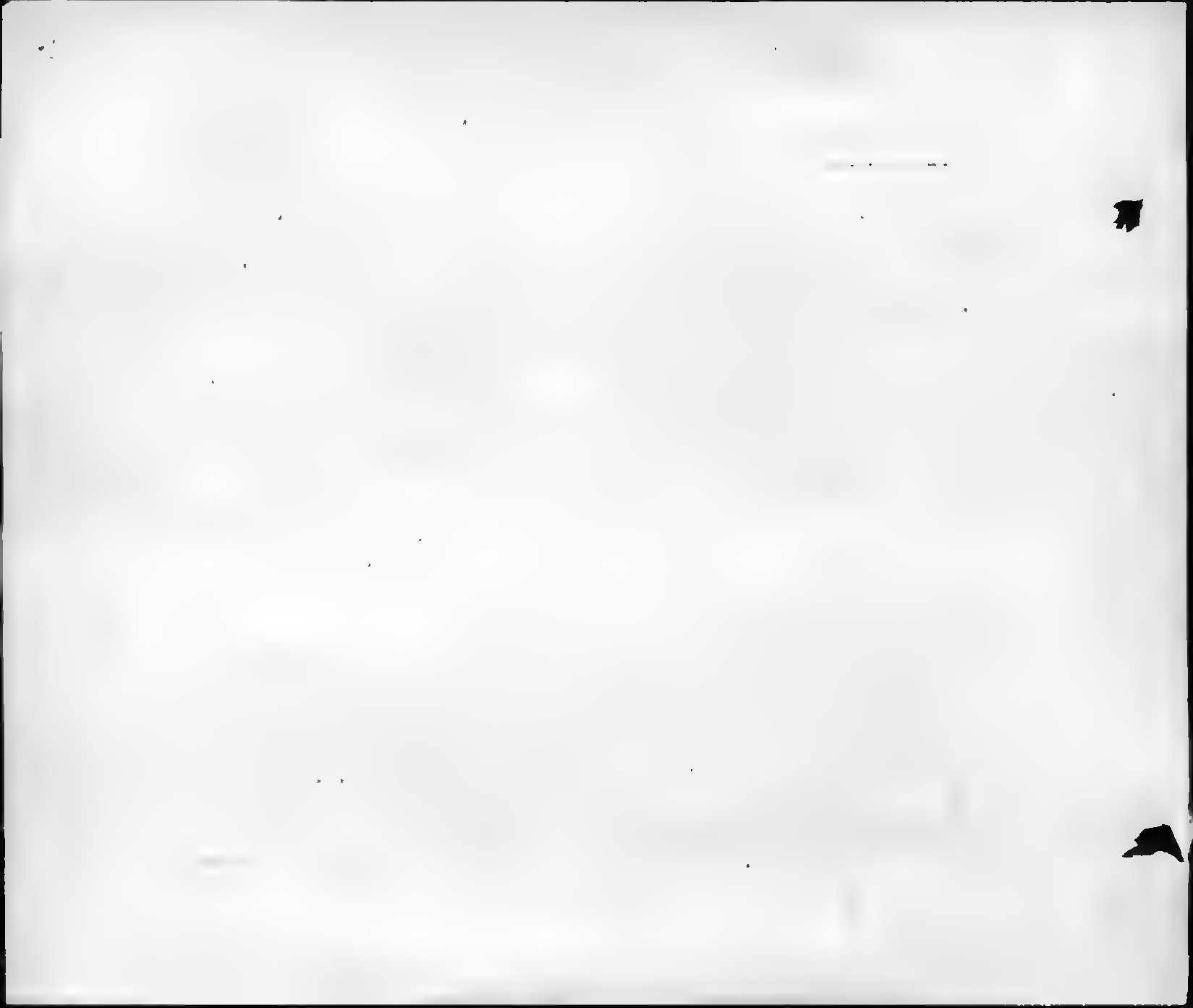
10594

Item 10-111492 (2) 10-1-60 at

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Cheverly c. LENGTH OF STAY IN 1b 3 hrs. 45 min		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 8206 Allentown Dr.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle Green Last Green		4. DATE OF DEATH Month Sept. Day 29 Year 1960			
5. SEX Fe.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ???	9. AGE (in years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 14 Days 6 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Poland		13. FATHER'S NAME Phelil Miller		14. MOTHER'S MAIDEN NAME Abraham Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Abraham Green Son Address 1234 - Buchanan St N. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Gangrene of left leg secondary to arterial occlusion. DUE TO (c) Generalized Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-28 19 60 , to 9-29 19 60 , that (I) (we) last saw the deceased alive on 9-28 19 60 , and that death occurred at 2:15 p.m. from the causes and on the date stated above.					
22a. SIGNATURE Ronald S. Fleischer		22b. ADDRESS 5432 Queen's Chapel Road, Hyattsville		22c. PHYSICIAN'S NAME (Type) Ronald S. Fleischer	
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 9/30-1960		23c. NAME OF CEMETERY OR CREMATORY Shelton Memorial Park Wash D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Hedley Funeral Home		25a. REC'D BY REGISTRAR OCT 3 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneel	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial-permission, or to burial-permission, or removal.

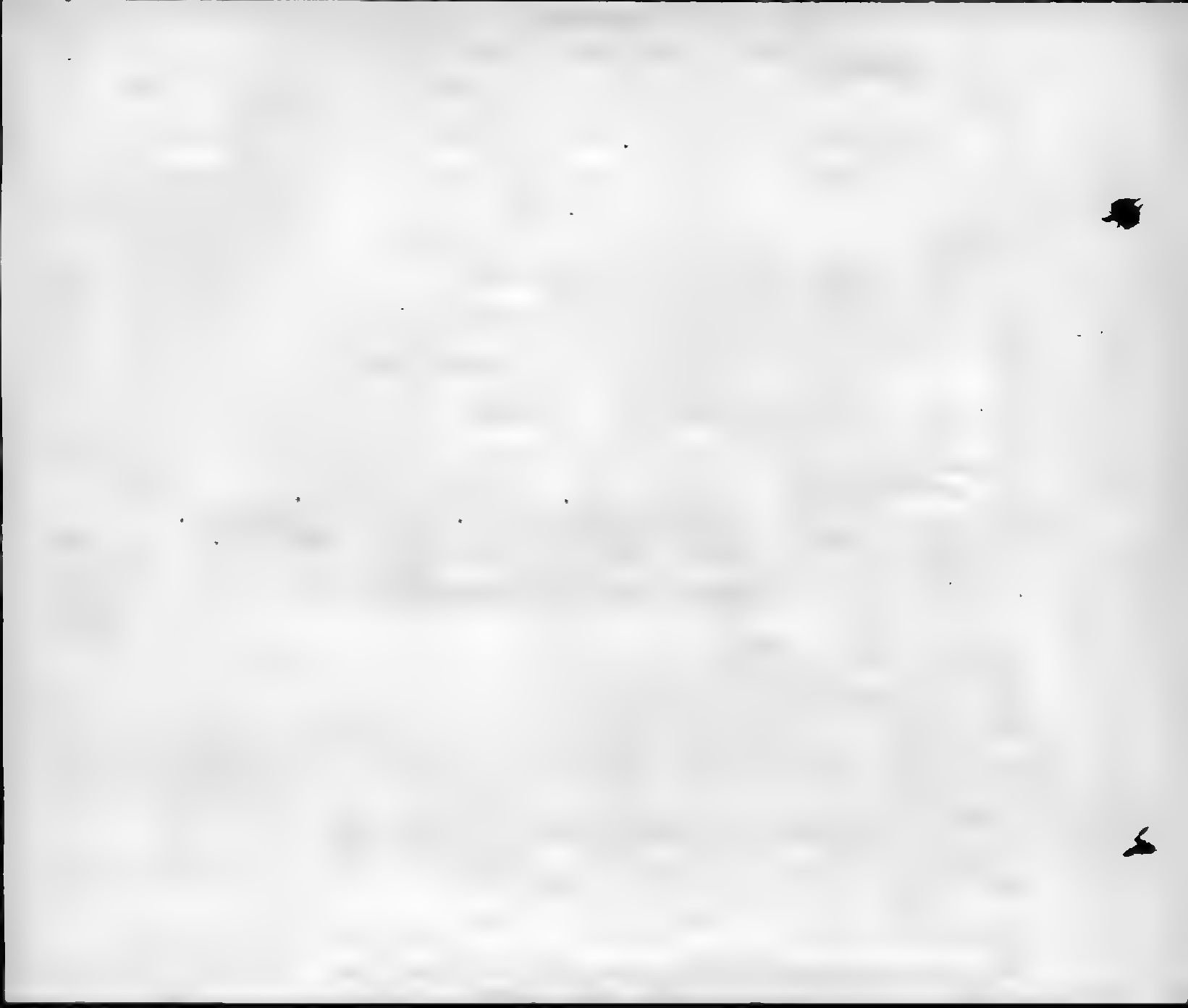
VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlesdale</u>		c. LENGTH OF STAY IN 1b <u>26.1.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Engine Lumber Memorial Hospital</u>		d. STREET ADDRESS <u>Exeter 26 Sexter ST</u>	
3. NAME OF DECEASED (Type or print) <u>RICHARD G GROVES</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>26,</u> Year <u>19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22-Aug 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard I Groves</u>		14. MOTHER'S MAIDEN NAME <u>Chora K. Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>816X</u>	
17. INFORMANT <u>Ruby H Richey</u>		Address <u>816X</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema. Bilateral hemothorax.</u> DUE TO <u>Congestive Heart Failure. Traumatic Myocarditis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple fractured ribs and costal cartilages.</u> DUE TO <u>Fractured Vertebra (T1 or T2)</u> (c) <u>Trauma From Automobile Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u> MV with MV	
20c. TIME OF INJURY Month, Day, Year Hour <u>1:15</u> a.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway Rte 1</u>		20f. (City or town) <u>Leitsville</u> (County) <u>F.G.</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton Owatkins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON OWATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Sept 30, 1960</u>		22b. DATE THEREOF <u>Sept 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cemetery</u>		22d. LOCATION (City, town, or county) <u>Colman Manor Md.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank S. Sons</u>		ADDRESS <u>4739 Bell Ave Hyattsville</u>	
24a. REC'D BY REGISTRAR <u>OCT 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Hines</u>	



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, at any time event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

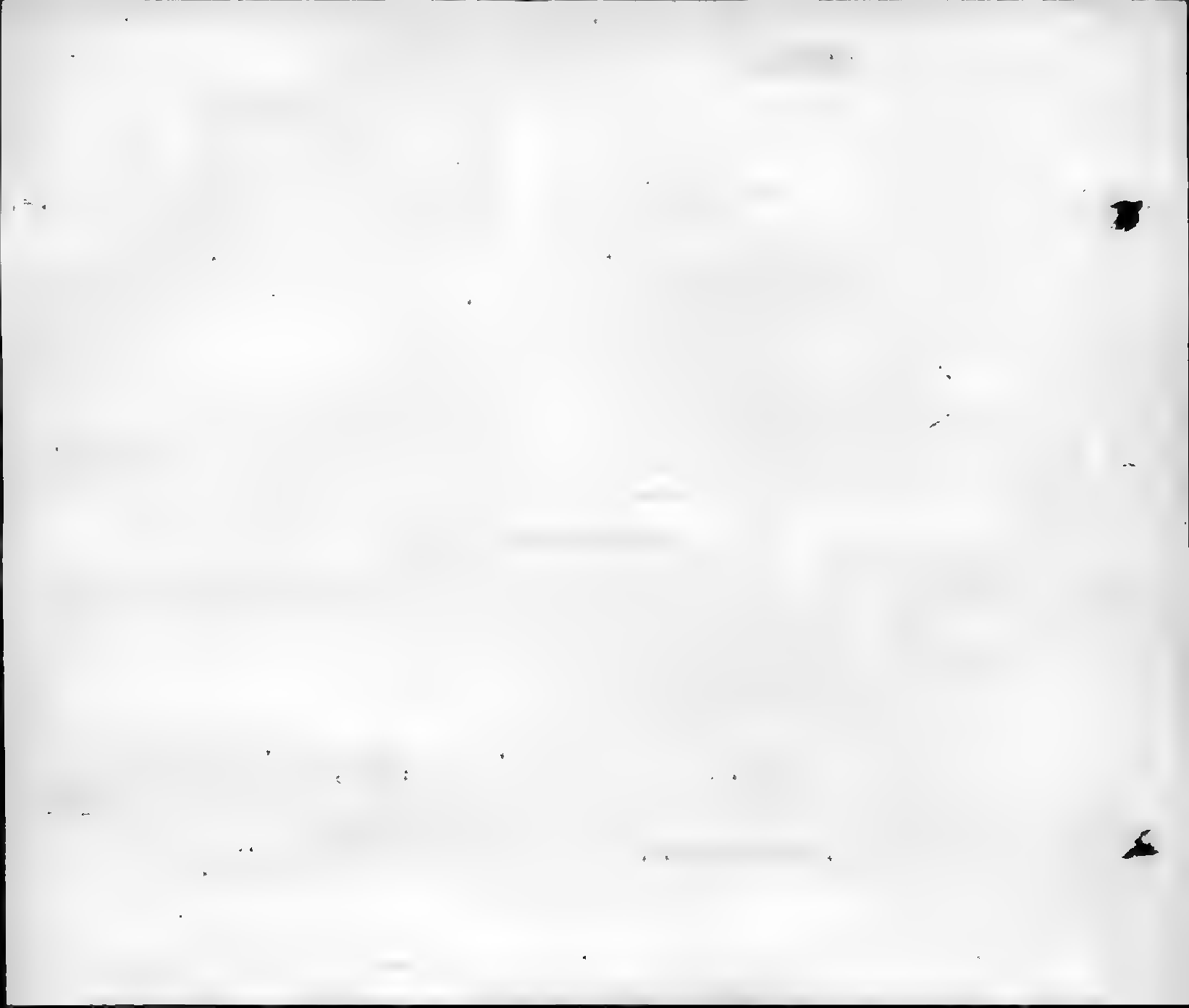
10600

CERTIFICATE OF DEATH

10596

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 Hr			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorothy Middle L. Last Hansbrough				4. DATE OF DEATH Month Sept. Day 18 Year 19 60			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1 1921	
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months 3 Days 18 Hours 18 Min.		11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington D C	
13. FATHER'S NAME Guy Lambden				14. MOTHER'S MAIDEN NAME Helen Forest			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Clarence R Hansbrough Carmody Hills Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Status Asthmaticus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1957 to Sept. 18, 1960 , that (I) (we) last saw the deceased alive on Sept. 17, 1960 and that death occurred at 1:10 P.M. , the causes and on the date stated above.							
22a. SIGNATURE Dr. Peter Duus				22b. DATE 9-19-60			
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus, M.D.				22d. ADDRESS 6124 Central Ave., Capitol Heights, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/60		23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City town or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE SEP 26 '60		25b. REGISTRAR'S SIGNATURE Clarence R Hansbrough	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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10597
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE KENTUCKY b. COUNTY MECKLENBURG			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.				c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2104 MONROE STREET.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hosp				d. STREET ADDRESS PADUCAH,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kathryn		First K.		Middle		Last 1davis	
4. DATE OF DEATH		Month 9		Day 7		Year 1960	
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/3/1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Davis Co		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Williams, John				14. MOTHER'S MAIDEN NAME Mary Elizabeth Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
				Kerol Gyro - 4408 Queensbury Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Pericardial Thrombosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Extensive heart failure							
(c) DUE TO Coronary atherosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/29/1960 to 9-7-1960, that (I) (we) last saw the deceased alive on 9-7-1960, and that death occurred at 4:05 PM, from the causes and on the date stated above.							
22a. SIGNATURE Chas H. Holton				M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Chas H. Holton				22d. ADDRESS 508 Anderson St. W. Paducah, Ky			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 9-9-1960		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) PADUCAH, KENTUCKY.	
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		25a. REC'D BY REG. STR. DATE SEP 13 '60	
						25b. REGISTRAR'S SIGNATURE (Print name)	



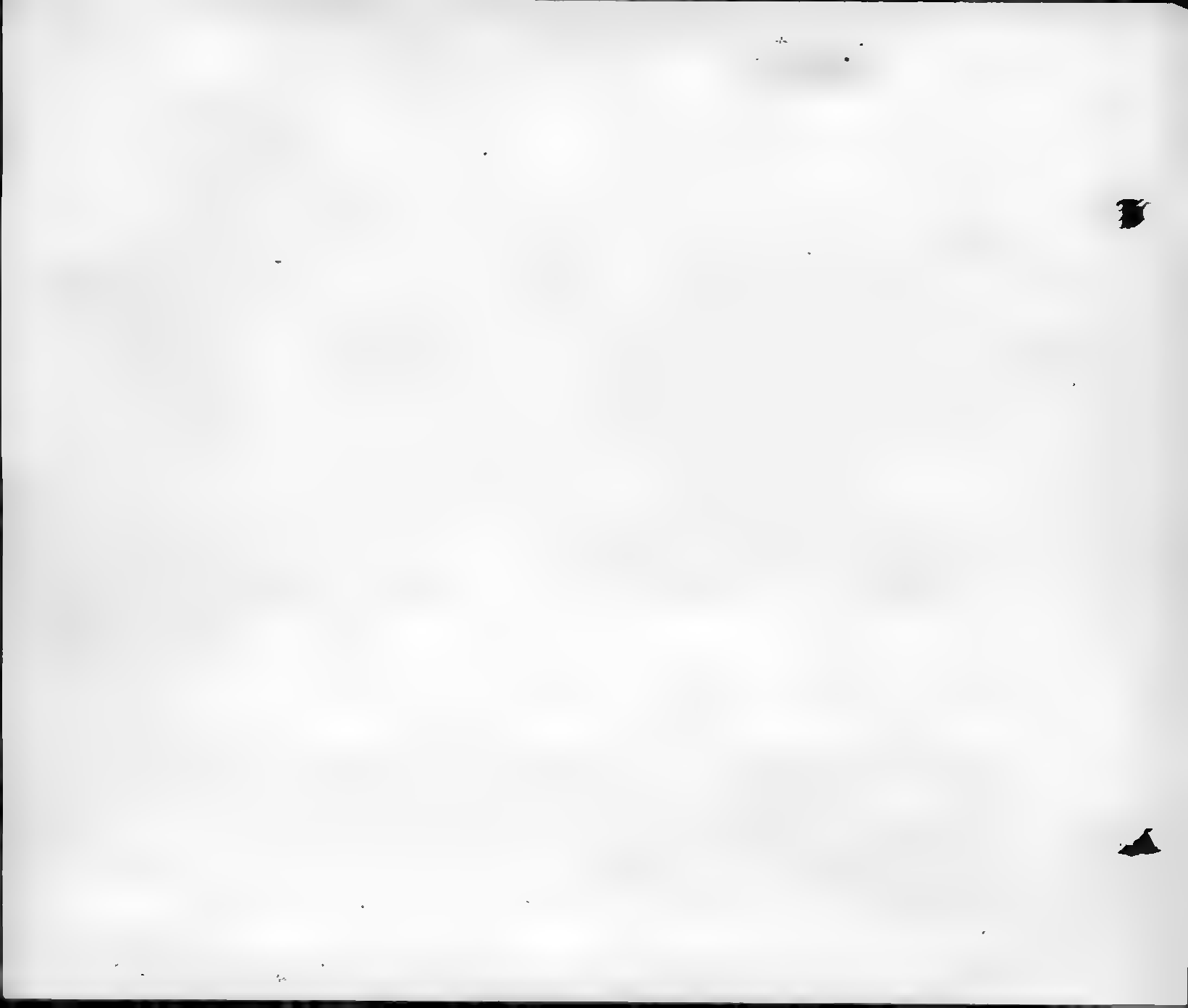
1

10653

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10598

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (AIRB)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS				d. STREET ADDRESS 314-2 ALASKA DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle L. Last HARTLEY				4. DATE OF DEATH Month SEPT Day 4 Year 1960			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 NOV 11	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 15 Min 00		IF UNDER 24 HRS. Hours 15 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN				10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOHN ROLAND HARTLEY				14. MOTHER'S MAIDEN NAME SUSAN HARTLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 205-07-2890		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarct. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH 1 hr.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (1) (this hospital) attended the deceased from 0415 4 Sept. 1960 to 0425 4 Sept. 1960 , that (2) (we) last saw the deceased alive on 4 Sept. 1960 , and that death occurred at 0425 AM, from the causes and on the date stated above.							
22a. SIGNATURE Edwin E. Westura				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 4 Sept. 1960	
22c. PHYSICIAN'S NAME (Type) EDWIN E. WESTURA CAPT USAF (MC)				22d. ADDRESS USAF HOSPITAL ANDREWS AFB, MD.			
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		7 SEPT 1960		ARLINGTON NATIONAL		ARLINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Ronald Howard Jones, Inc.				ADDRESS 816 H St. N.E. DC 2		25a. REC'D BY REGISTRAR DATE SEP 7 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Howard			



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10601

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10599

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. LENGTH OF STAY IN 1b 36 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theodore Middle A. Last Heslop				4. DATE OF DEATH Month Sept. Day 27 Year 1960			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-20-02	
9. AGE (In years lost birthday) 58 yrs		10. IF UNDER 1 YEAR Months 5 Days 7 Hours 15 Min 00		11. BIRTHPLACE (State or foreign country) Wilkes Barre, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Model maker				10b. KIND OF BUSINESS OR INDUSTRY Model Basin			
13. FATHER'S NAME William Heslop				14. MOTHER'S MAIDEN NAME Anna Stout			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Byron Heslop, Son		17. INFORMANT Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 36h DUE TO (c) Interval BETWEEN ONSET AND DEATH							
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-20-60 to 9-27-60 that (I) (we) last saw the deceased alive on 9-26-60 and that death occurred at 7:15 A.M. on the causes and on the date stated above.							
22a. SIGNATURE Ronald Fleischer M.D.				22b. DATE SIGNED 9/27/60			
22c. PHYSICIAN'S NAME (Type) Ronald Dr. Ronald Fleischer				22d. ADDRESS 5432 Queens Chapel Rd N, Hyattsville			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/30/60		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home Inc. ADDRESS 10101 Rte. 1, Gaithersburg, Md.				25a. REC'D BY REGISTRAR Oct 3 1960 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Finner	

3-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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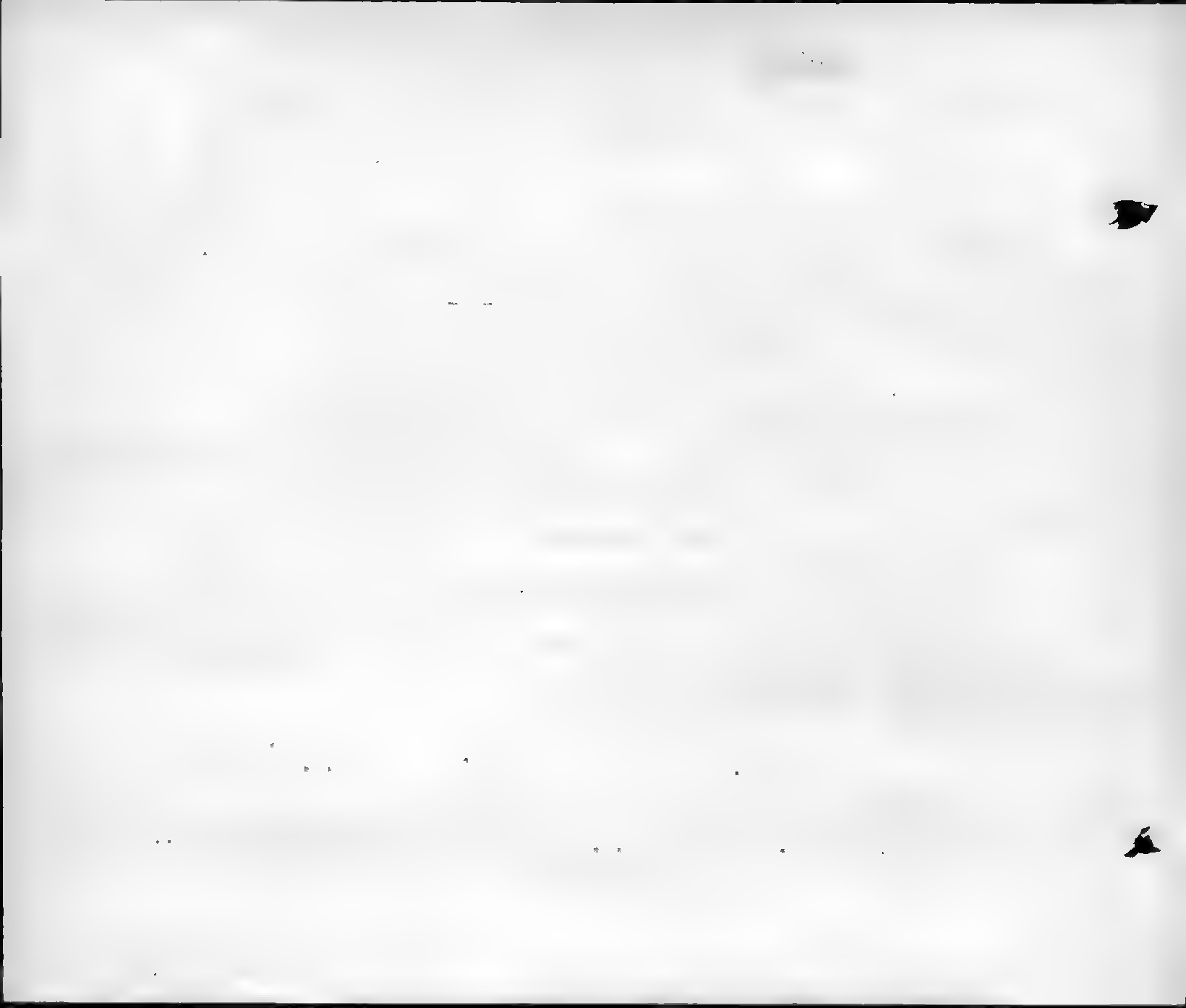
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10602

CERTIFICATE OF DEATH

10600

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 6850 Freeport St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice		First Middle Last Hildebrand		4. DATE OF DEATH Month Sept. Day 13 Year 19 60			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-86		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John L. Wilson				14. MOTHER'S MAIDEN NAME Mary L. Emmerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Margaret Peterson-6850 Freeport St Address Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis DUE TO (c) Diabetes Melletis						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 8 19 60 Sept. 13 19 60 that (I) (we) lost saw the deceased alive on Sept. 13 19 60 and that death occurred at 11:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ronald S. Fleischer M.D.				22b. DATE 9-13-60		22c. PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER	
22d. ADDRESS 5432 QUEENS CHAPEL RD. Hyattsville, Md.				22e. ADDRESS 5432 QUEENS CHAPEL RD. Hyattsville, Md.			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF 9/17/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. W. L. L. L. 300 4th ST NE				25a. REC'D BY REGISTRAR DATE SEP 19 '60		25b. REGISTRAR'S SIGNATURE Anthony S. Kneiss	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10654

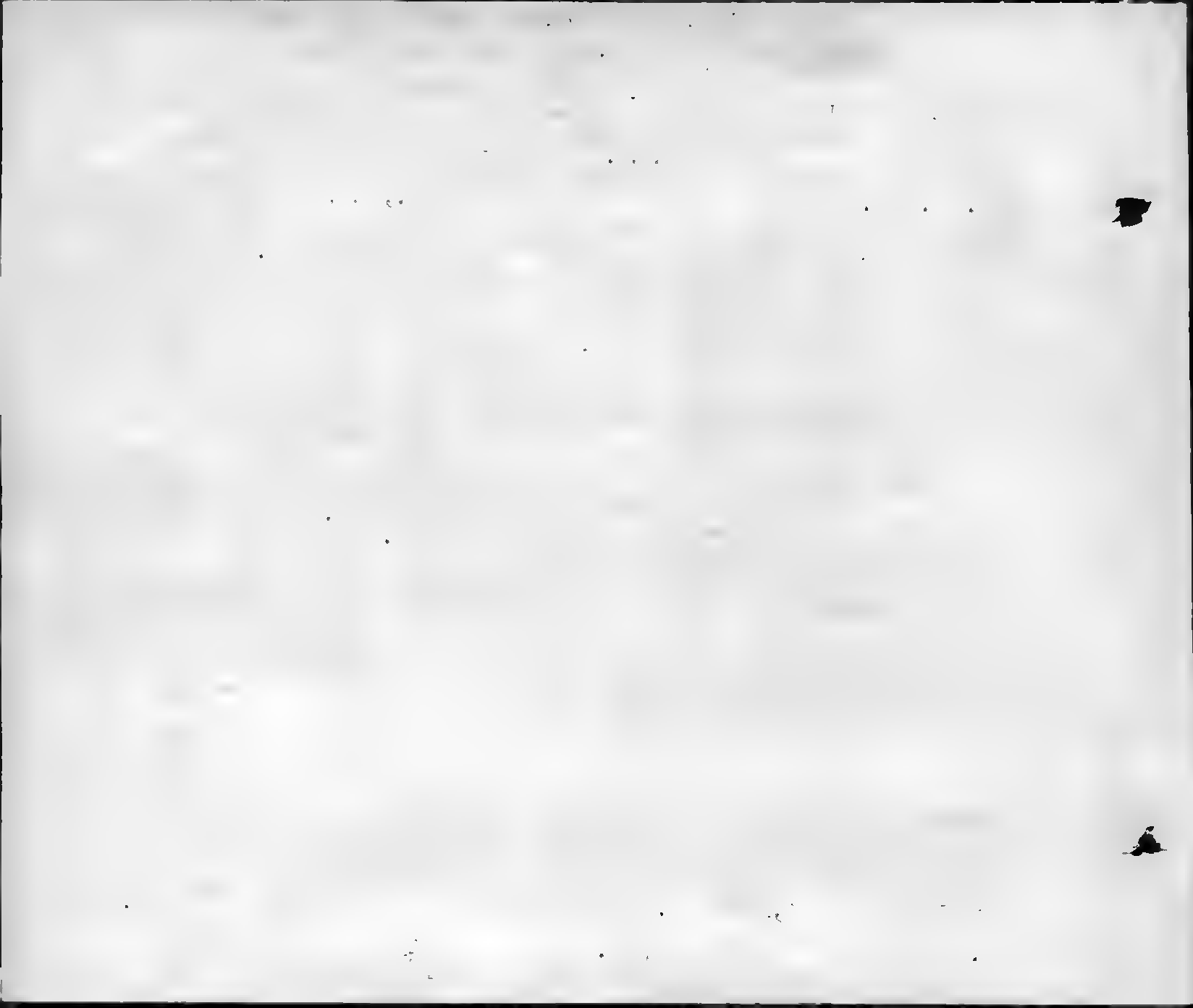
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2a Film G273 15-18-60 et

Reg. Dist. No.

10602

1. PLACE OF DEATH COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE England b. COUNTY Lancashire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blackpool 16X-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) So. Md. Med. Center		d. STREET ADDRESS 13 High St., N.S.	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last CHRISTOPHER HINDLE		4. DATE OF DEATH Month Day Year Sept. 30 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 March 1891
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Guard		10b. KIND OF BUSINESS OR INDUSTRY British R.R.	11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? England		13. FATHER'S NAME William Hindle	
14. MOTHER'S MAIDEN NAME Martha		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Minnie Hindle (Wife) Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of the brain stem secondary to infarction of medial wall of left auricle. DUE TO Mural Thrombus of Left auricle. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO Coronary Arteriosclerotic Heart Disease Generalized Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE DAYTON O WATKINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF # Oct 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR OCT 4 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	



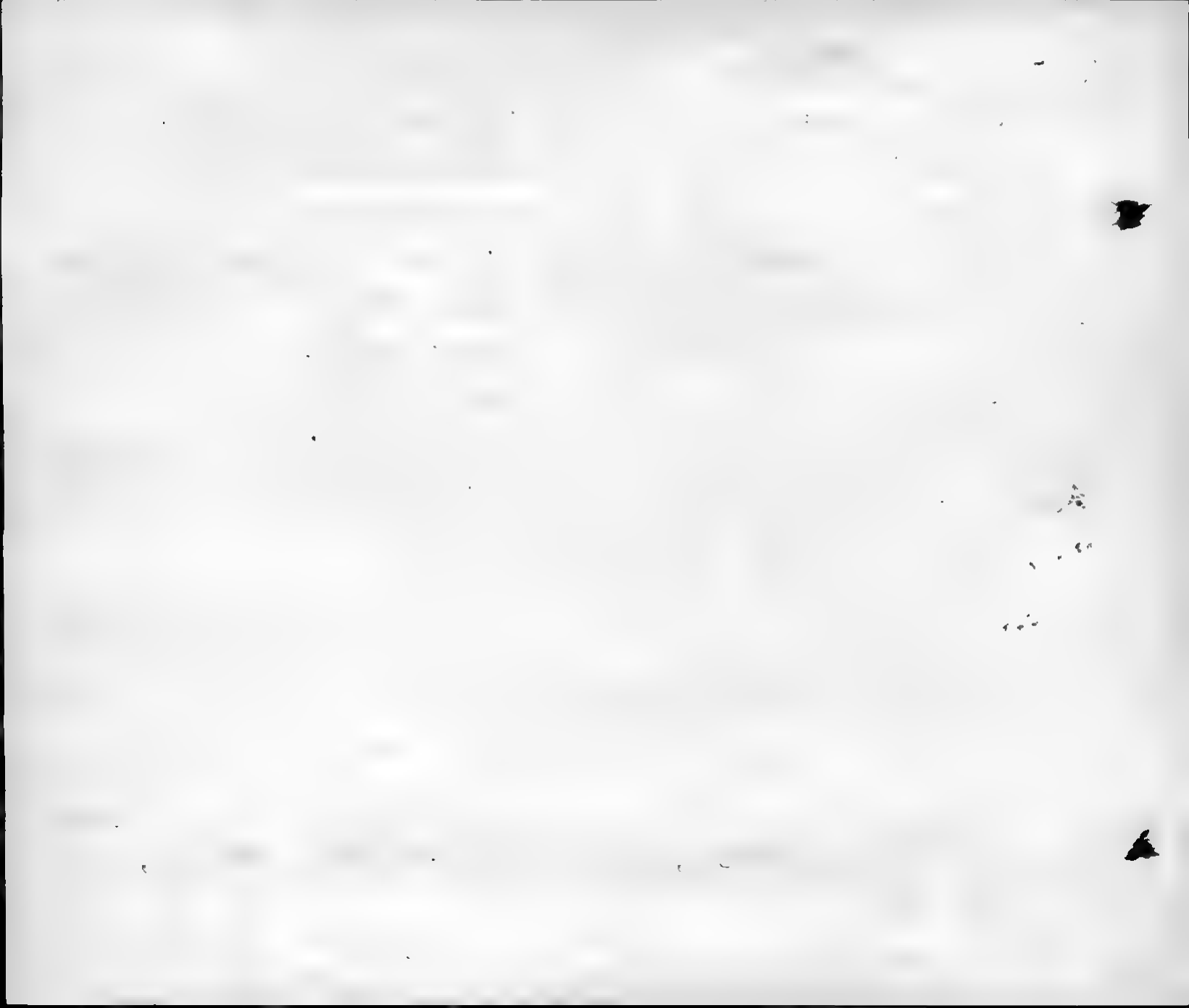
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

VR A15 (4)
15M-9-59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10636
CERTIFICATE OF DEATH
10601

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MORNINGSIDE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>HOME</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MORNINGSIDE</u> d. STREET ADDRESS <u>415 MAPLE RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK RICHARD HILL</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 21 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 JUNE 1960</u>
9. AGE (in years last birthday) yrs. <u>3</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES V. HILL</u>		14. MOTHER'S MAIDEN NAME <u>DONNA J. SANFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u> (If yes, give year or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DONNA J. HILL (Mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UNKNOWN CAUSE (long Heart Dis</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Venous pulm. Return)</u> (c) <u>(Patent For. valve)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>21 SEP 1960</u> to <u>21 SEP 1960</u> that (I) (we) last saw the deceased alive on <u>NEVER</u> 19 <u>60</u> , and that death occurred at <u>21 SEP 1960</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William H Peniston</u> M.D.		22b. DATE SIGNED <u>21 Sep 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM H PENISTON, MAJ USAF MC</u>		22d. ADDRESS <u>USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-23-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Suitland MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661-Good Hope Rd SE WASH DC</u>		25a. RECEIVED BY REGISTRAR DATE <u>SEP 26 60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

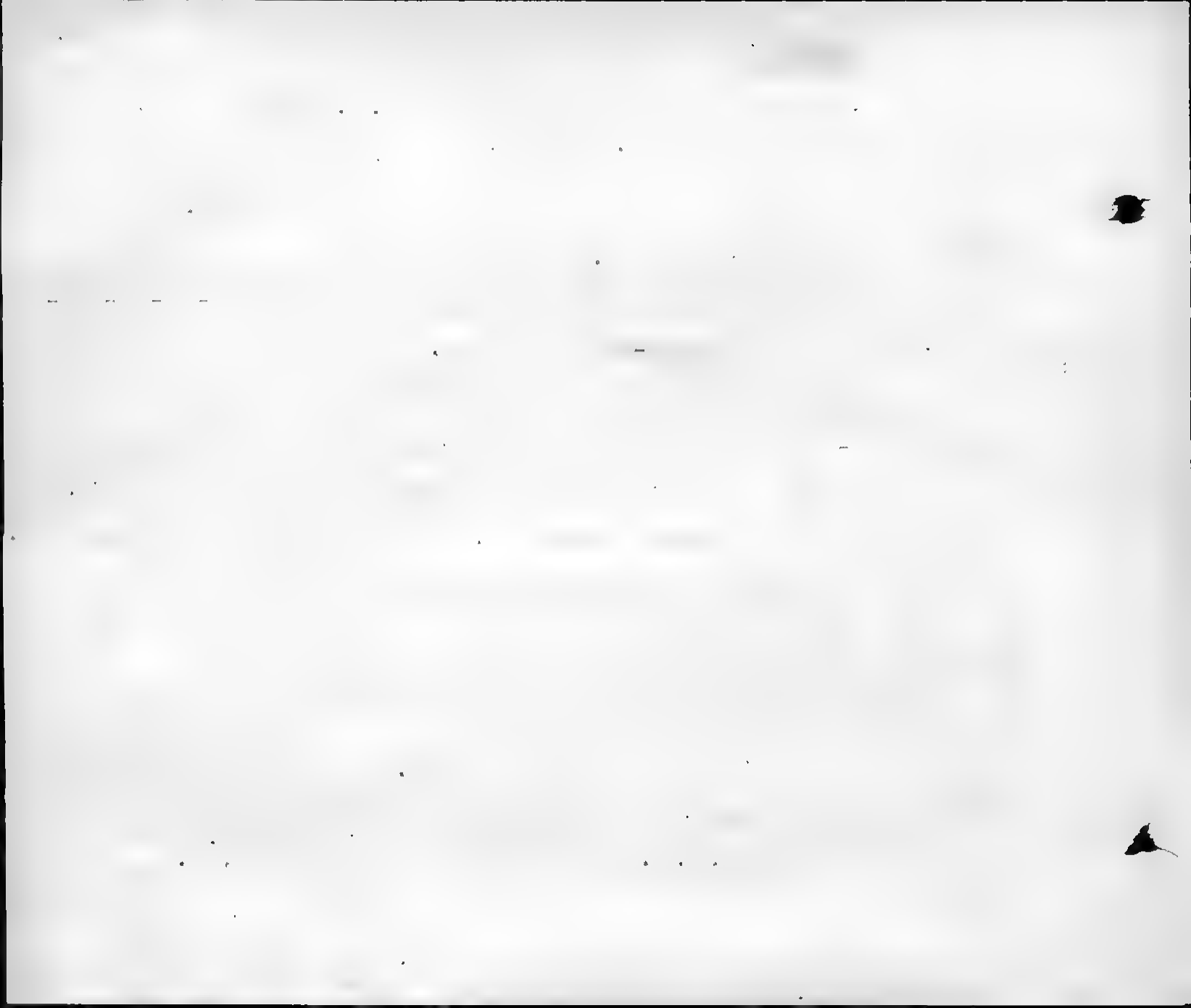
10655

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10603

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE D. C. b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 2 yrs., 5 months, and 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
f. STREET ADDRESS 115 Longfellow St., NW				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucy Middle I. Last Holden				4. DATE OF DEATH Month 9 Day 30 Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/26	9. AGE (In years last birthday) 33 yrs	IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Walter Peterson				14. MOTHER'S MAIDEN NAME Hester Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. (lost) Unknown		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Hemorrhage 002X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (b) Pulmonary Tuberculosis, Far Advanced DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH 5 min. 3 yrs, 2 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 4/16 5-15 1958, to 9/30 1960, that (I) (we) last saw the deceased alive on 9/30/1960 , and that death occurred at 4 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 9/30/60			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
REMOVAL		Oct 1, 1960		WESTMORELAND County, VA.		VA.	
24. FUNERAL DIRECTOR'S SIGNATURE David M. Weldon				25a. REC'D BY REGISTRAR Oct 1, 1960			
ADDRESS Oldham, VA				25b. REGISTRAR'S SIGNATURE Oct 6, '60			

Arthur S. K...



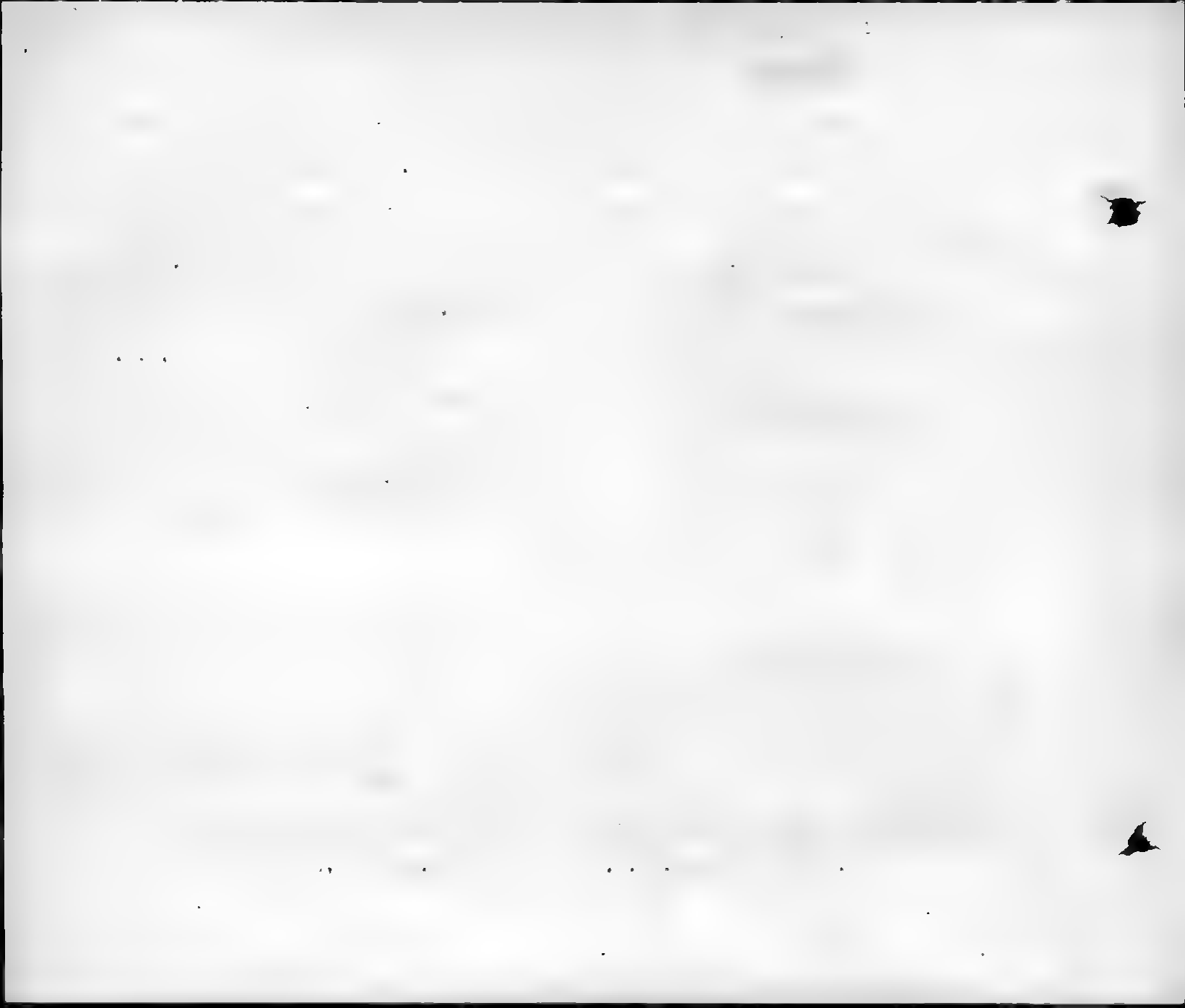
may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10604

10603

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georgea			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince GeorgesGeneral Hospital				d. STREET ADDRESS Palmer Park, 7467 83rd Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Babette Ann Holland			4. DATE OF DEATH Month 12 Day Sept. Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Sept. 1960		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min	IF UNDER 24 HRS. Hours 2 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Francis Holland			14. MOTHER'S MAIDEN NAME Bernice M Gibson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO		17. INFORMANT Mother Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 782.5 Aortic aneurysm, bilateral DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 9-10 1960 to 9-12 1960 that (I) (we) last saw the deceased alive on 9-12 1960 and that death occurred at 6:45 PM from the causes and on the date stated above.							
22a. SIGNATURE George Hageage			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/13/60		
22c. PHYSICIAN'S NAME (Type) Dr. George Hageage, M.D.			22d. ADDRESS Mt. Rainier, Md.				
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/14/60		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City, town, or county) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE P. Gasch's Sons Hyattsville, Md.			ADDRESS		25a. REC'D BY REGISTRAR SEP 16 60 DATE		25b. REGISTRAR'S SIGNATURE Walter J. Hume



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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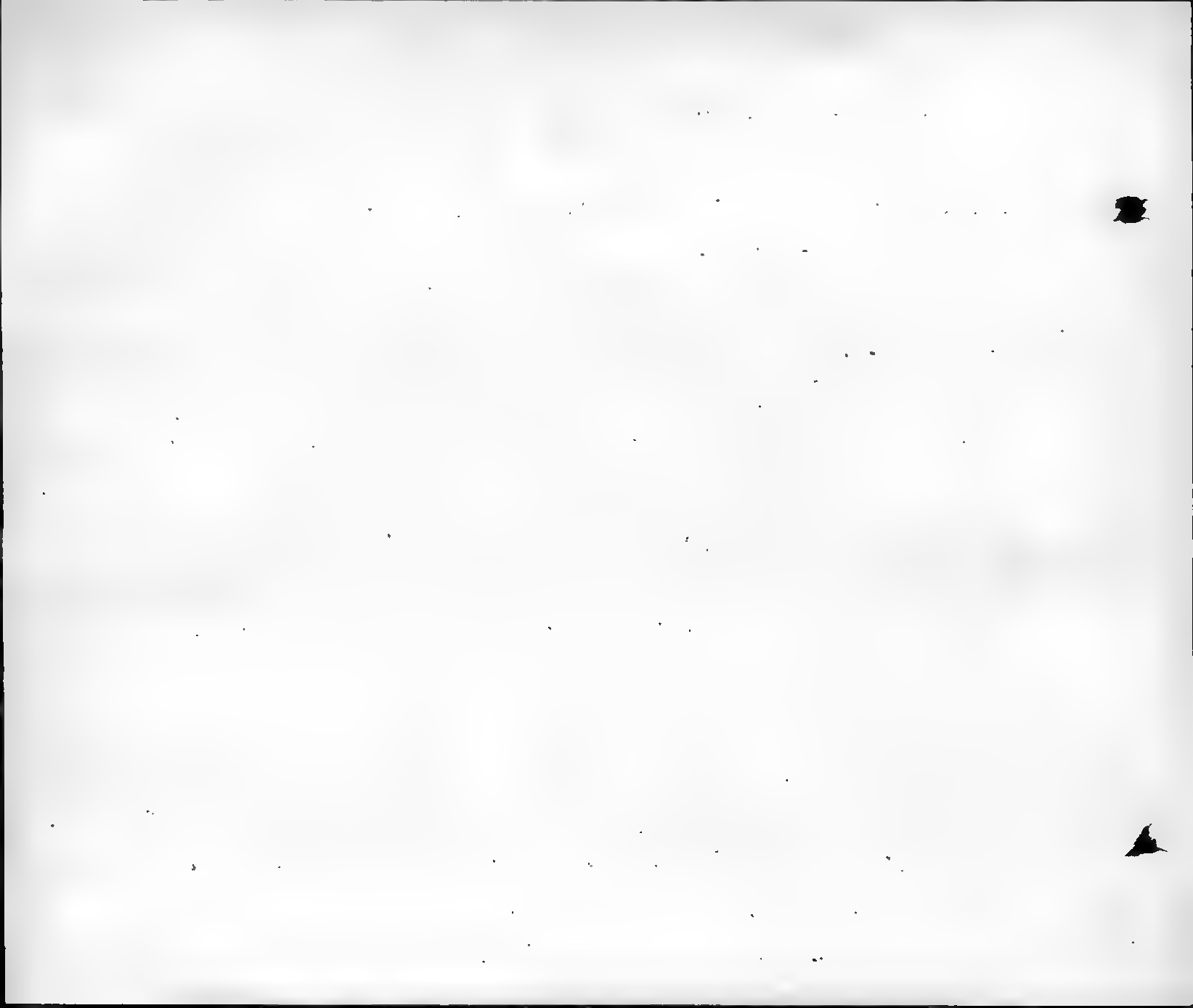
VS A15 (4)
15M 9/58

10571 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8,9 Filed 9-27-60 et
CERTIFICATE OF DEATH

Reg. Dist. No.

10605

1. PLACE OF DEATH a. COUNTY PRINCE George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL Manor 4922 LaSalle Rd.		d. STREET ADDRESS 1947-39th St. N.W.	
3. NAME OF DECEASED (Type or print) First Anna Middle Jansen Last Tansen		4. DATE OF DEATH Month Sept Day 11 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875 6-5-1884
9. AGE (In years and high day) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Popenburg, Germany		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Lambert Jansen		14. MOTHER'S MAIDEN NAME Adelaide Meyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT SR. M. FRANCIS PATRICIA		Address 4922 LA SALLE RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cerebral Thrombosis DUE TO (b) generalized Arterio Sclerosis DUE TO (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auricular fibrillation - congestive failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. , 19 59 , to Sept 11 , 19 60 , that I last saw the deceased alive on Sept 10 , 19 60 , and that death occurred at 5:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. Tilley, Jr.		ADDRESS (Street, city or town, state) Wash D.C. DATE SIGNED 9-11-60	
PHYSICIAN'S NAME (Type) Russell M. Tilley, Jr.		ADDRESS 4701 Mass. Ave. N.W., Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 9-14-1960	
22c. NAME OF CEMETERY OR CREMATORY MT. CALVARY - PINE HILL		22d. LOCATION (City, town, or county) (State) BUFFALO, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Jr. Lawrence Sander		24. REGISTRAR'S SIGNATURE Arthur S. Kneer	
ADDRESS 1556 Pennsylvania Ave. N.W., Wash. D.C.		DATE SEP 13 '60	



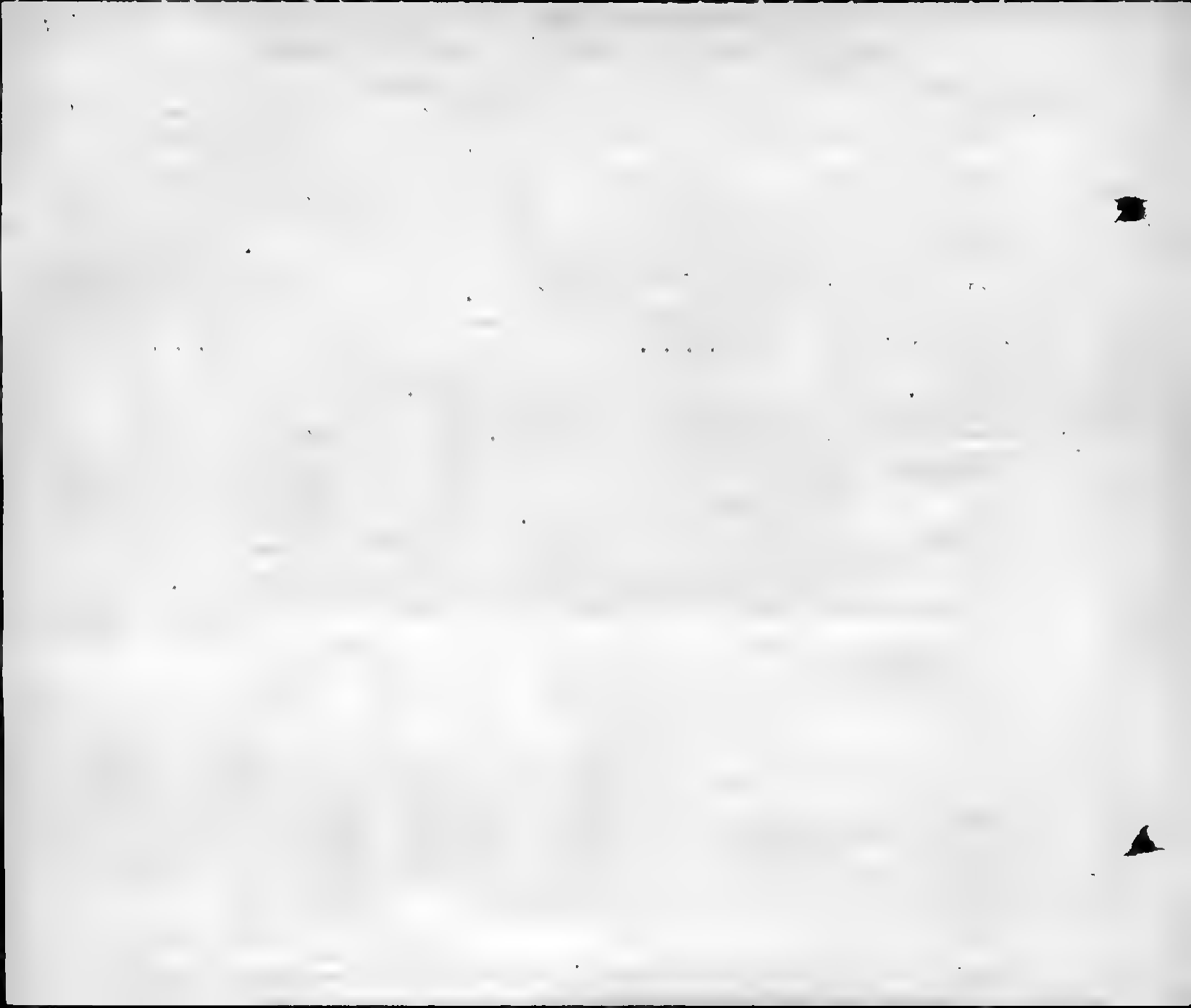
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10634 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10606**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel Md c. LENGTH OF STAY IN lb Sudden d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel Md Shopping Center				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville 02 d. STREET ADDRESS 12415 Gun Powder Road									
3. NAME OF DECEASED (Type or print) MAHLON First ARTHUR Middle JOHNSON Last				4. DATE OF DEATH Sept. Month 22 Day 19 Year 60									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 Jan. 1894		9. AGE (In years 66 yr. 6 mo. 0 day)		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Expeditor				10b. KIND OF BUSINESS OR INDUSTRY E.R.C.O.				11. BIRTHPLACE (State or foreign country) Maine				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert A. Johnson						14. MOTHER'S MAIDEN NAME Margaret E. Conley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give year or dates of service) WWI				16. SOCIAL SECURITY NO. 311056891		17. INFORMANT Nina A. Johnson Address Same as # 2 (Wife)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis secondary to embolization from 420 DUE TO Mural Thrombus. Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Mural Thrombus and old Myocardial Infarction DUE TO (c) Coronary Occlusion, left anterior descending, old. </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH Minutes Weeks Weeks </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checkbox"="" type="checkbox/> and find that death resulted from: Natural causes <input type="/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.													
ACTUAL SIGNATURE <i>Dayton Watkins</i> M.D. EXAMINER'S NAME (Type) DAYTON O WATKINS						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Sept 26, 1960		22c. NAME OF CEMETERY OR INTERMENT Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.						24a. REC'D BY REGISTRAR DATE SEP 27 '60		24b. REGISTRAR'S SIGNATURE <i>Charles S. Frank</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the date, time, and place of death in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10604 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>18 Seat Pleasant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>				e. STREET ADDRESS <u>215-78 St</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD NORMAN JOHNSTON</u>				4. DATE OF DEATH Month Day Year <u>Sept 20 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 May 30</u>	
9. AGE (In years last birthday) <u>30 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>last posted</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward C. Johnston</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude W. Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>578-36-8053</u>		17. INFORMANT <u>Bonita G. Johnston</u> Address <u>Sanear #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive Pontine Hemorrhage few hrs</u> DUE TO (b) <u>C Rupture into 4th verticle</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Symona Bro.</u> ADDRESS <u>10661-20th Hwy Rd SE WASH DC</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>ing S. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10656

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10608

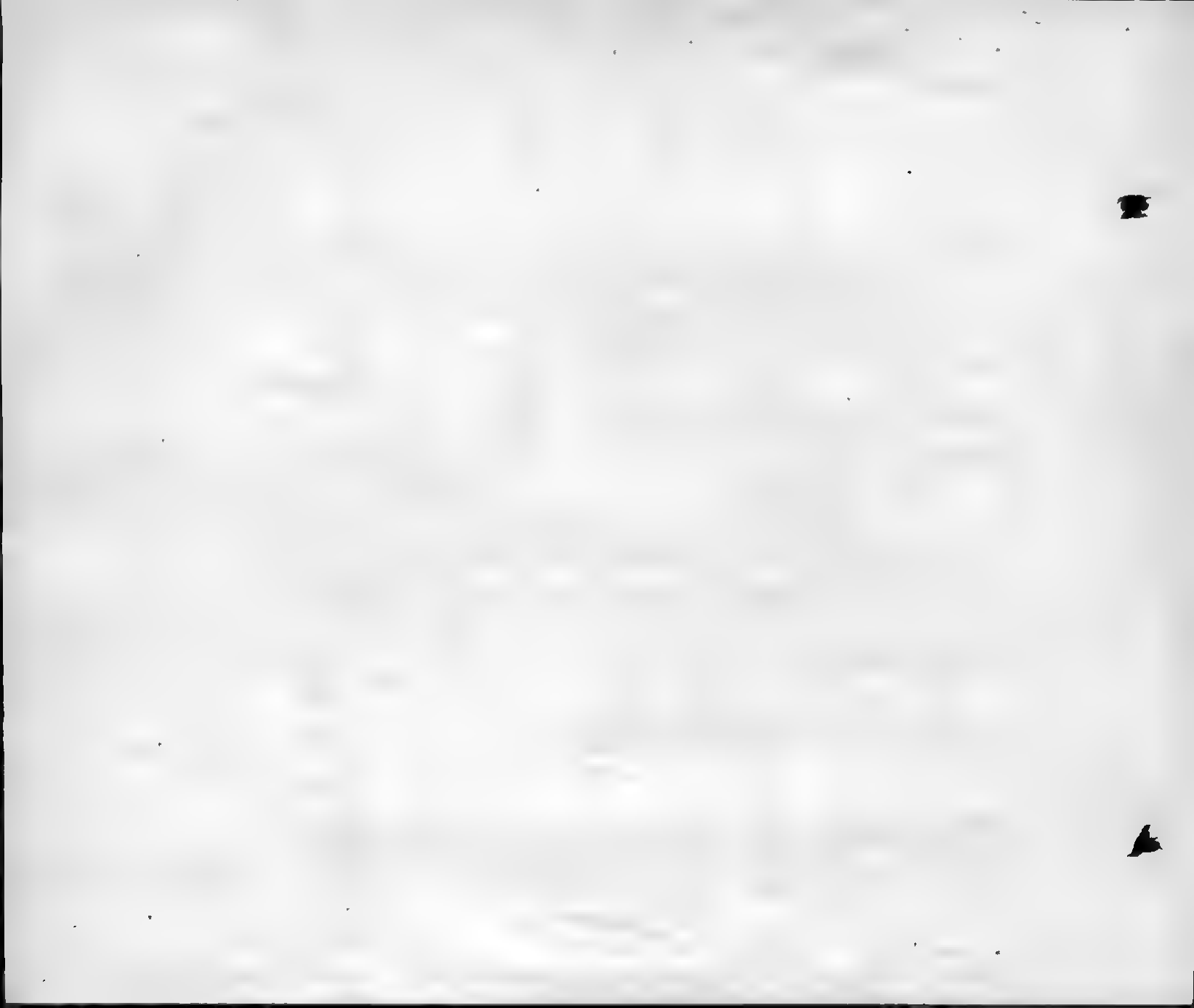
Item 7 filed 10-6-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md.		c. LENGTH OF STAY in 1b Transit	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coeburn		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Highway			d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Clarence B Jones			4. DATE OF DEATH Month Day Year September 25, 19 60		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1924		9. AGE (In years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Coal Miner	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Mathew J. Jones			14. MOTHER'S MAIDEN NAME Lizzie M Mooney		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 223 24 1450	17. INFORMANT Robert L Jones Indian Head Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812 X Wounds multiple & severe DUE TO Fracture skull Fracture neck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Compound fracture hip, Fracture femur					INTERVAL BETWEEN ONSET AND DEATH not
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY (a) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Automobile accident - Pedestrian			
20c. TIME OF INJURY Month Day Year Sept 24 1960 Hour m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Indian Head Pr Geo	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Dayton O Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-25-60	
EXAMINER'S NAME (Type) DAYTON O WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/27/60	22c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery		22d. LOCATION (City, town, or county) (State) Austinville Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland		24a. REC'D BY REGISTRAR DATE OCT 3 '60	
				24b. REGISTRAR'S SIGNATURE W. S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10657

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10609

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution. Residence before admission, a. STATE D. C. b. COUNTY D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale, Md.		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. STREET ADDRESS 318 15th Pl. N.E.	
3. NAME OF DECEASED (Type or print) Spirana First Jones Middle Jones Last		4. DATE OF DEATH Sept. 3 1960 Month Sept. Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1883
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR 10 + yrs IF UNDER 24 HRS Unknown	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY So. Carolina	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Tony McKnight		14. MOTHER'S MAIDEN NAME Eliza Atkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Self.	
17. INFORMANT Self.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia 443X DUE TO Cerebro-Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertensive & Arteriosclerotic Ht. Dis. DUE TO Unknown PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 Day 10 + yrs Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 8/22/60 Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/22/60 to 9/3 19 60 that (I) (we) last saw the deceased alive on 9/3 19 60 , and that death occurred at 8:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 9/4/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital	
23a. BURIAL CREMATION REMOVAL (Specify) 9/4/60		23b. DATE THEREOF New Harmony	
23c. NAME OF CEMETERY OR CREMATORY Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE A. E. Washington ADDRESS A 444		25a. REC'D BY REGISTRAR SEP 7 '60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

Hall Bros. F.H., 621 Florida Ave., NW, Washington, D.C.

4 3 0 0 0 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

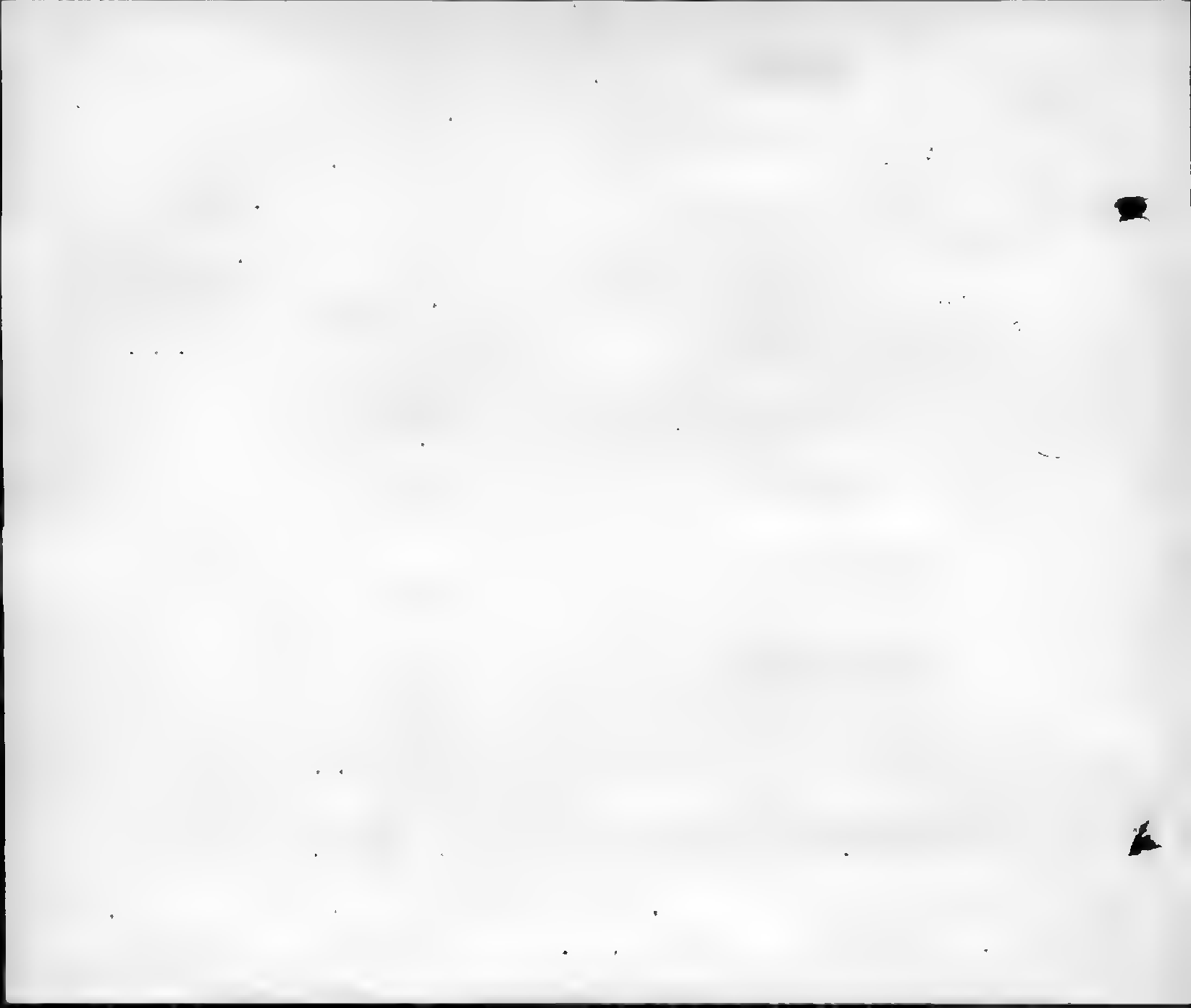
10610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLMAR MANOR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GASH FUNERAL HOME</u>		d. STREET ADDRESS <u>3616-39 ave</u>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>MARIE</u> Last <u>GAYLOR</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Oct 1921</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>KIETH M GAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET J. Jumper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-12-2491</u>	
17. INFORMANT <u>VINCENT KOS</u>		Address <u>211 - 4 ST SE WASHINGTON DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA</u> DUE TO (b) <u>HEPATIC FAILURE</u> DUE TO (c) <u>CIRRHOSIS LIVER</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic alcoholism</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> NOT while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-10-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Riverdale, Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 19 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>Colburn B. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10606

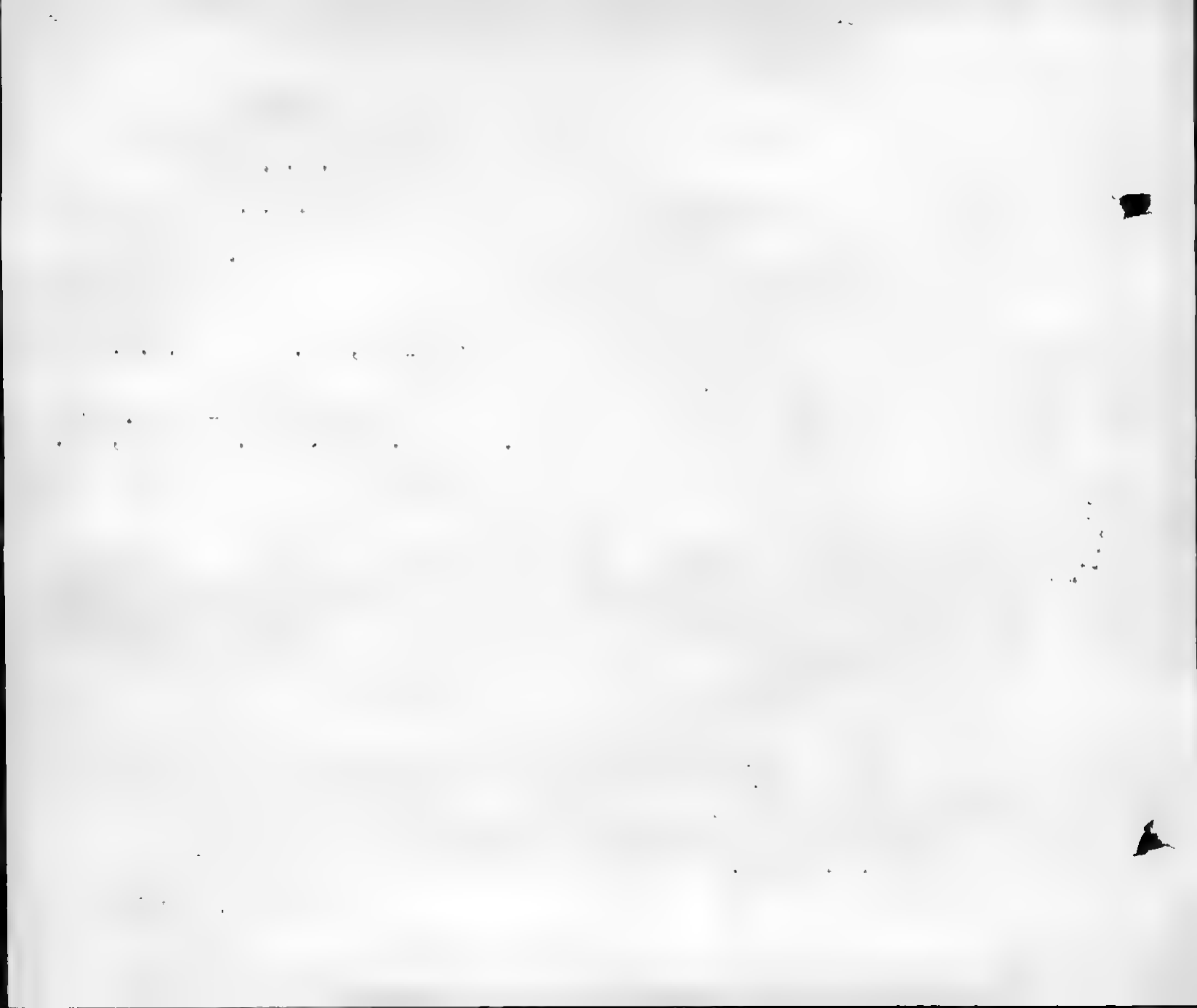
10612

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
c. LENGTH OF STAY IN 1b 36 days		d. STREET ADDRESS 314 16th St. N.E.	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gernie Middle M. Last Lambert		4. DATE OF DEATH Month Sept. Day 21 Year 19 60	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 May 1899
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min. 11. IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Churchville, Va.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Bright		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 4005-36th.street	
17. INFORMANT Mrs. Ruby S. Rhodes Mt. Rainier, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation (clinical) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post thyroidectomy for (c) thyroid carcinoma	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Oct 1957 to Sept 1960 that (I) (we) last saw the deceased alive on Sept 20, 1960 , and that death occurred at 1:30A from the causes and on the date stated above.			
22a. SIGNATURE Dr. B. Miller		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. B. Miller		22d. ADDRESS 3824-34th St. Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/1960	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Churchville, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Kalley's Funeral Home, Inc.		25a. REC'D BY REGISTRAR DATE SEP 23 '60	
ADDRESS Mt. Rainier Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

M

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10607

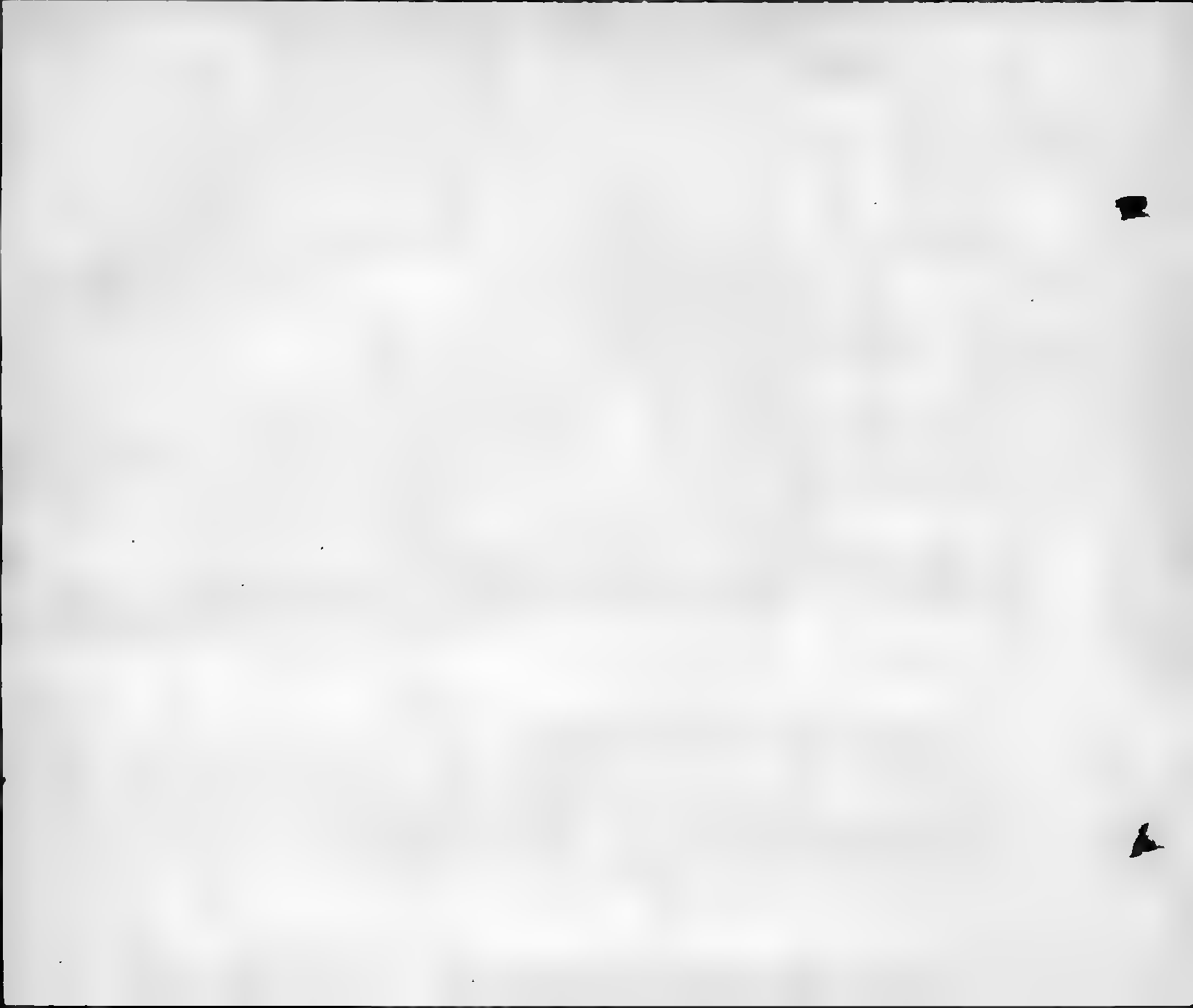
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo Hospital</u>			d. STREET ADDRESS <u>202 Trenton PL SE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>LANKOSZ</u> Last <u>LANKOSZ</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10 - 1945</u>	9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.I.C.</u>
13. FATHER'S NAME <u>ADAM R. LANKOSZ</u>			14. MOTHER'S MAIDEN NAME <u>Isabelle McLAY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>		17. INFORMANT <u>Adam Lankosz above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERCRANIAL HEMORRHAGE</u> DUE TO <u>CEBRAL CONCUSSIONS +</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>LACERATIONS, FRACTURE SKULL</u> DUE TO <u>inst</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>inst</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <u>DC</u> CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Riding a Bicycle & Struck by a truck</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		9-1-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-3-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Pr Geo</u>		22e. (State) <u>DC</u>		22f. (Country) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. F. Jones</u>		ADDRESS <u>741-11th St. S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		24c. (City, town, or county) <u> </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH43. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

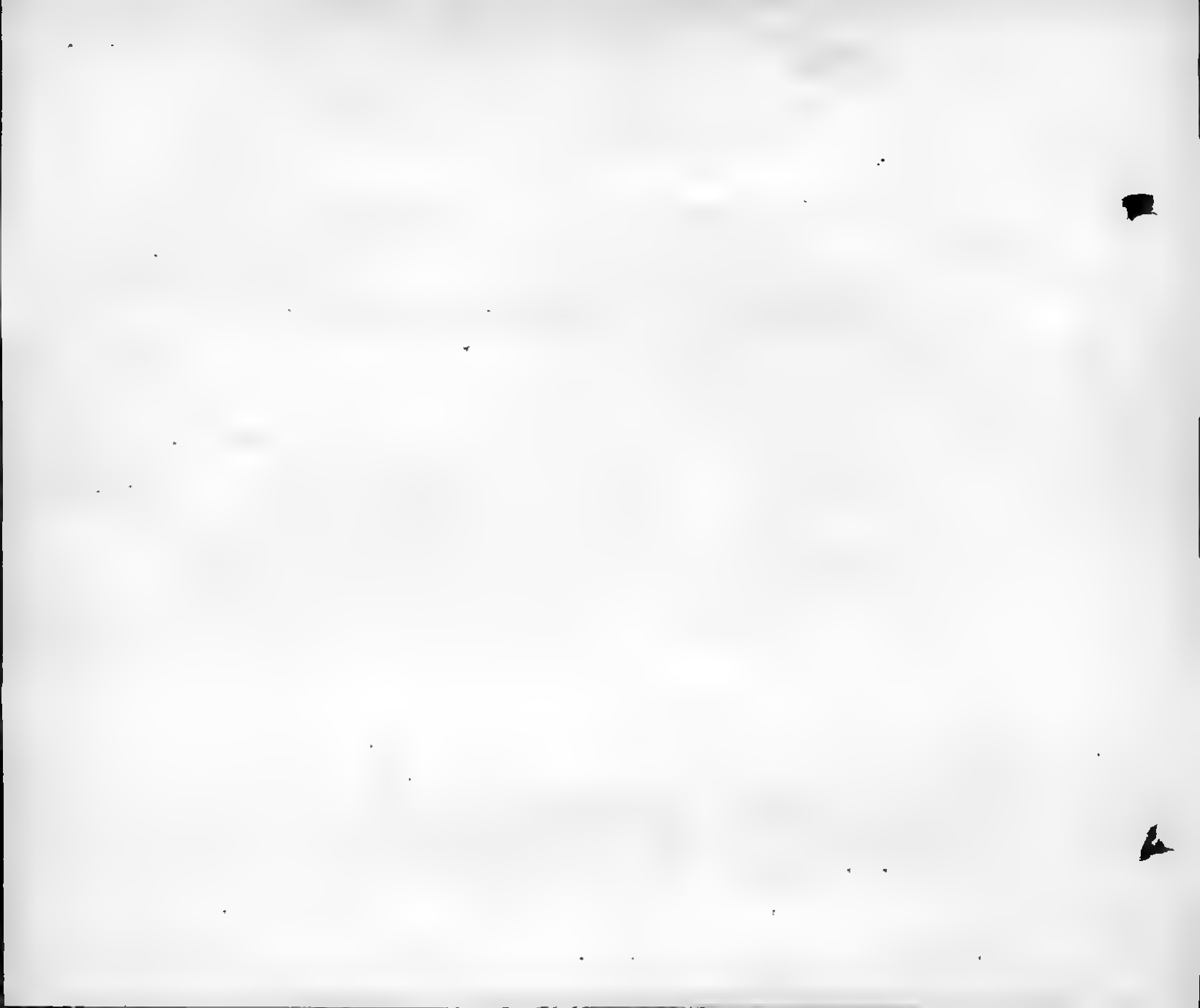
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10608

10614

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 31 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4707 Amherst Road			
3. NAME OF DECEASED (Type or print) First Esther Middle Lee Last Lee				4. DATE OF DEATH Month Sept Day 10 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/87		9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Chio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert B Cristy				14. MOTHER'S MAIDEN NAME Whilemina Lindsley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Alfred R Lee Address College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO 170X Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno carcinoma breast DUE TO 1YR. (c)							INTERVAL BETWEEN ONSET AND DEATH 2 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) College Park		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 9 19 60 to Sept 10 19 60 that (I) (we) last saw the deceased alive on 9/10/60 19 60 , and that death occurred at 11AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Norman A. ...</i> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 9/10/60	
22c. PHYSICIAN'S NAME (Type) Dr. N. Comeau				22d. ADDRESS 3503 Penny St Mt Rainier Md			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 13, 1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
				25b. REGISTRAR'S SIGNATURE <i>Charles S. ...</i>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10615

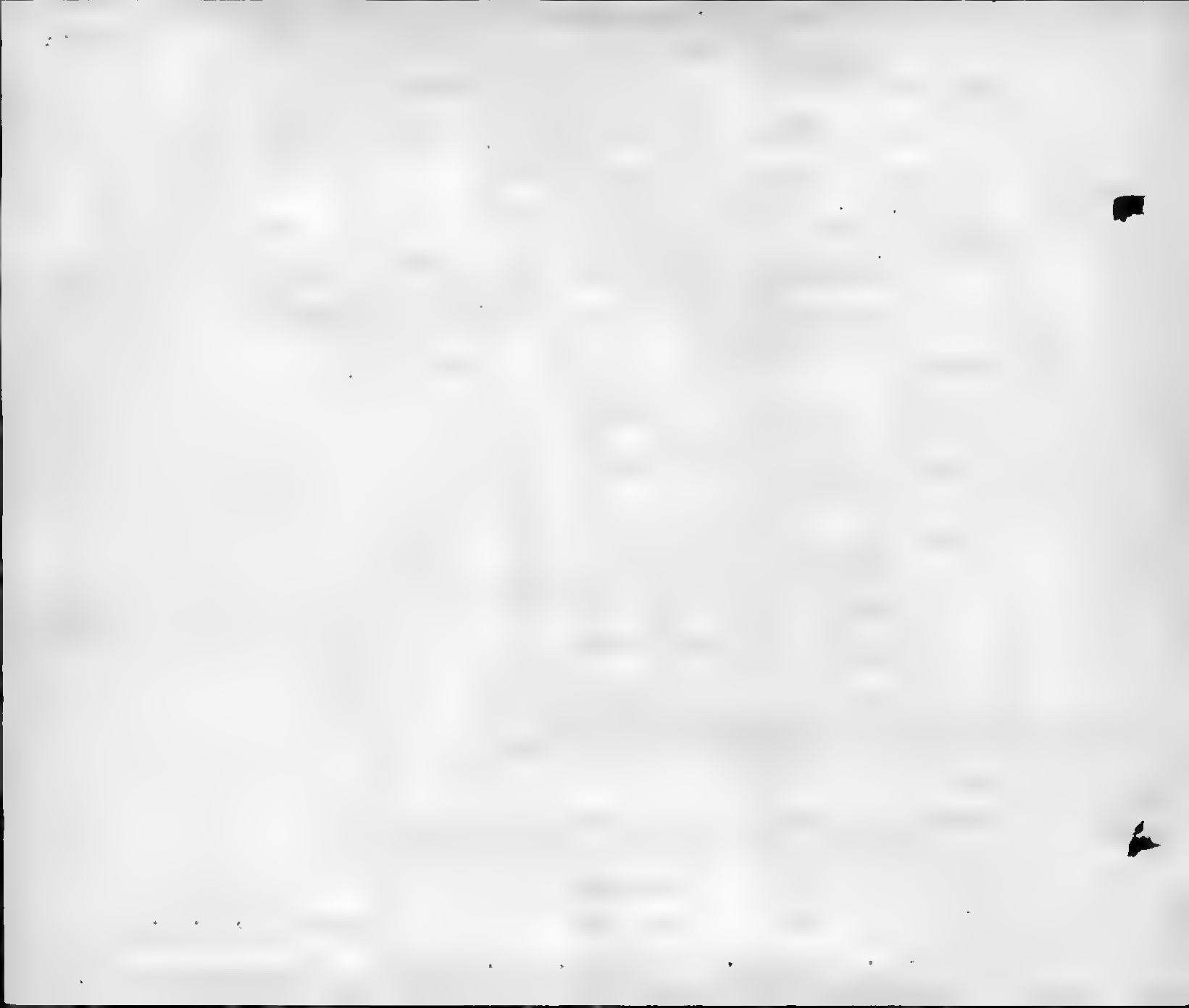
10609

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PRINCE GEORGES</u>				d. STREET ADDRESS <u>3512 MADISON PL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PETER</u> Middle <u>CHARLES</u> Last <u>LYNARD</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-1909</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 MRS. Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT PROP.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CONSTANTINE LYNARD</u>				14. MOTHER'S MAIDEN NAME <u>GIANOLIA DOWNIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Lynard</u> <u>MRS. ROSE MARIE (Wife) (SAME)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>433.0</u> DUE TO <u>Stokes Adams Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. A. Hines Co. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 20 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

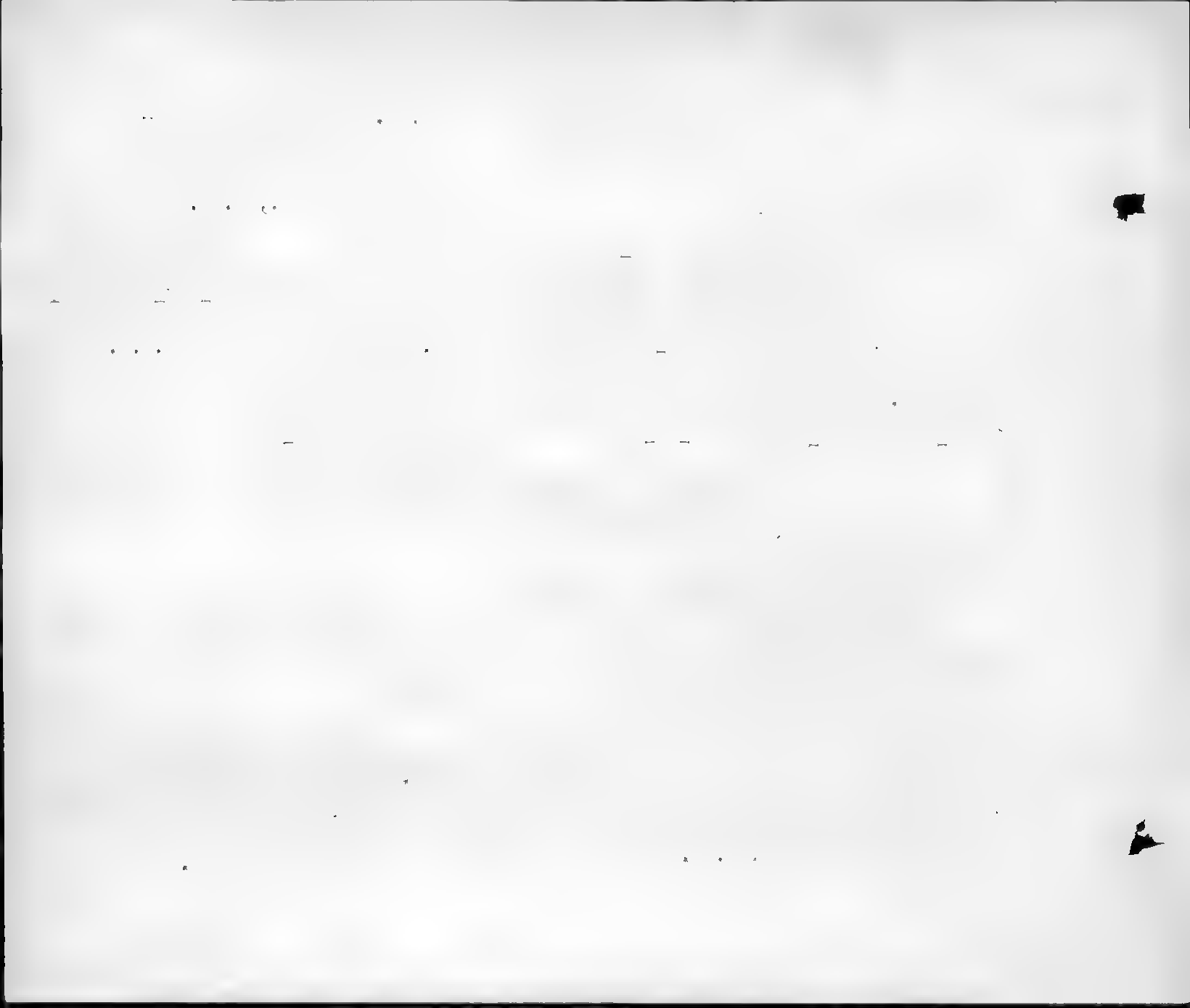


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>10658</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>10616</p> </div> </div>																					
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u> c. LENGTH OF STAY IN 1b <u>3 days</u>					2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>805 1/2 10th St., N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>-</u> Last <u>Mansfield</u>					4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1960</u>																
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8/3/14</u>		9. AGE (In years last birthday) <u>46</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min.	-	-	-	-
IF UNDER 1 YEAR		IF UNDER 24 HRS																			
Months	Days	Hours	Min.																		
-	-	-	-																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>														
13. FATHER'S NAME <u>James E. Mansfield</u>					14. MOTHER'S MAIDEN NAME <u>Ethel May</u>																
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>579-09-3308</u>		17. INFORMANT <u>Decedent</u>			Address <u>-</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laennec's cirrhosis with insufficiency and hepatic coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> (c) <u>-</u> DUE TO <u>-</u>									INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>Bronchopneumonia</u>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>																		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>														
21. I certify that (I) (this hospital) attended the deceased from <u>9/2/1960</u> to <u>9/5/1960</u> , that (I) (we) last saw the deceased alive on <u>9/5/1960</u> , and that death occurred at <u>11:45 A. M.</u> , from the causes and on the date stated above																					
22a. SIGNATURE <u>Moe Weiss</u>					M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9/5/60</u>														
22c. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>					22d. ADDRESS <u>Glenn Dale Hospital Glenn Dale, Md.</u>																
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE HEREON <u>SEP 6, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>															
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>					ADDRESS <u>Riverdale, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 8 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>												



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10610 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

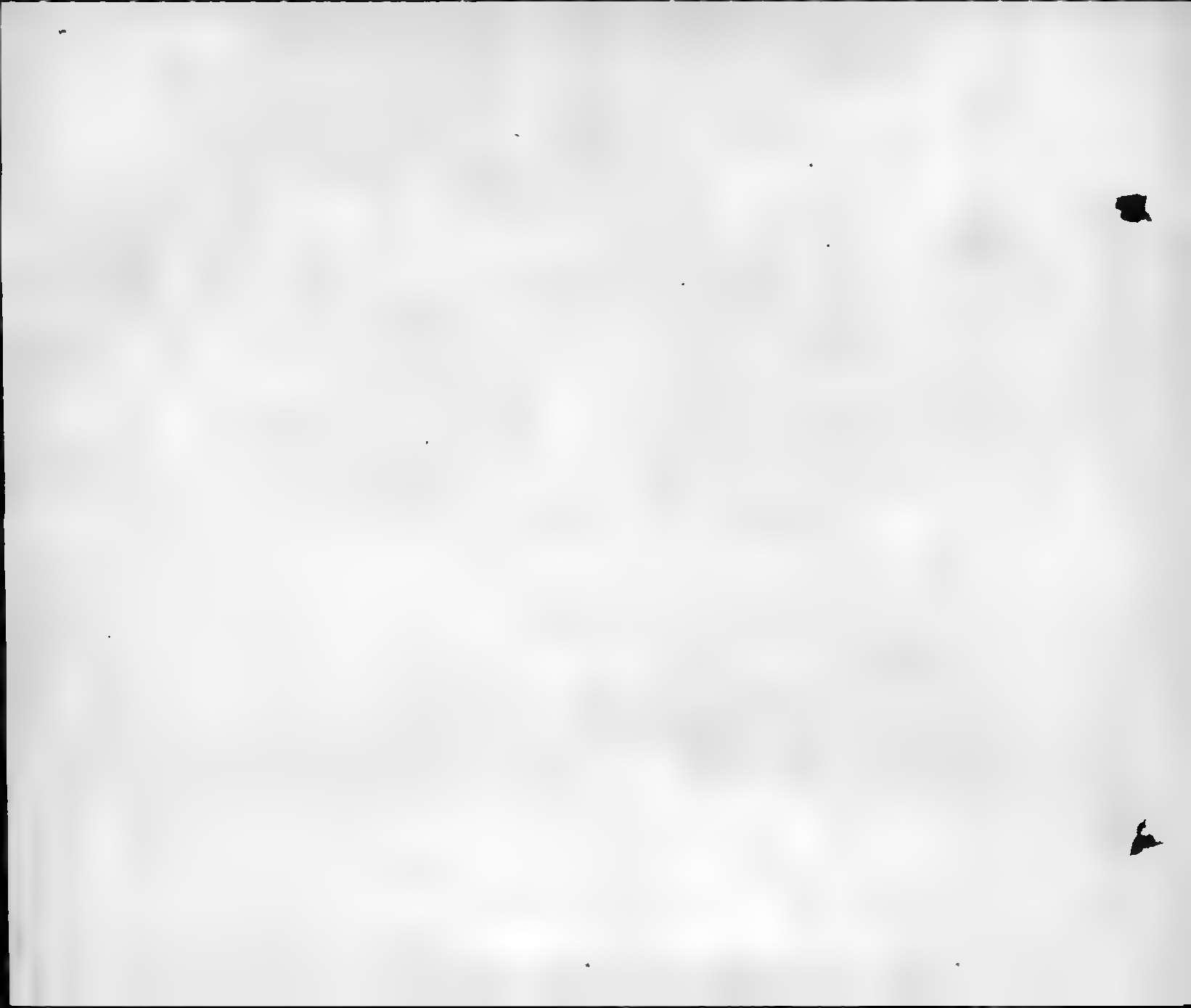
10617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>El Paso</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>El Paso Texas</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>10080 Imperial Street</u>			
3. NAME OF DECEASED (Type or print) <u>DORIS SKINNER</u> Middle <u>McCool</u> Last				4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>19 60</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>May 17, 1913</u>		9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Chester Pa</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				13. FATHER'S NAME <u>Charles Wesley Skinner</u>			
14. MOTHER'S MAIDEN NAME <u>Jessie M Dorsey</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Wm A Mc Cool</u> <u>El Paso Texas</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 422-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL FIBROSIS</u> DUE TO (c) <u> </u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>inst</u> <u>years</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Borhitate Habituation</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dayton O. Wattens</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-9-60</u>			
EXAMINER'S NAME (Type) <u>DAYTON O. WATTENS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Port Republic Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. Gasch's Sons Hyattsville Md.</u>					
24a. REC'D BY REGISTRAR <u>SEP 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hanna</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

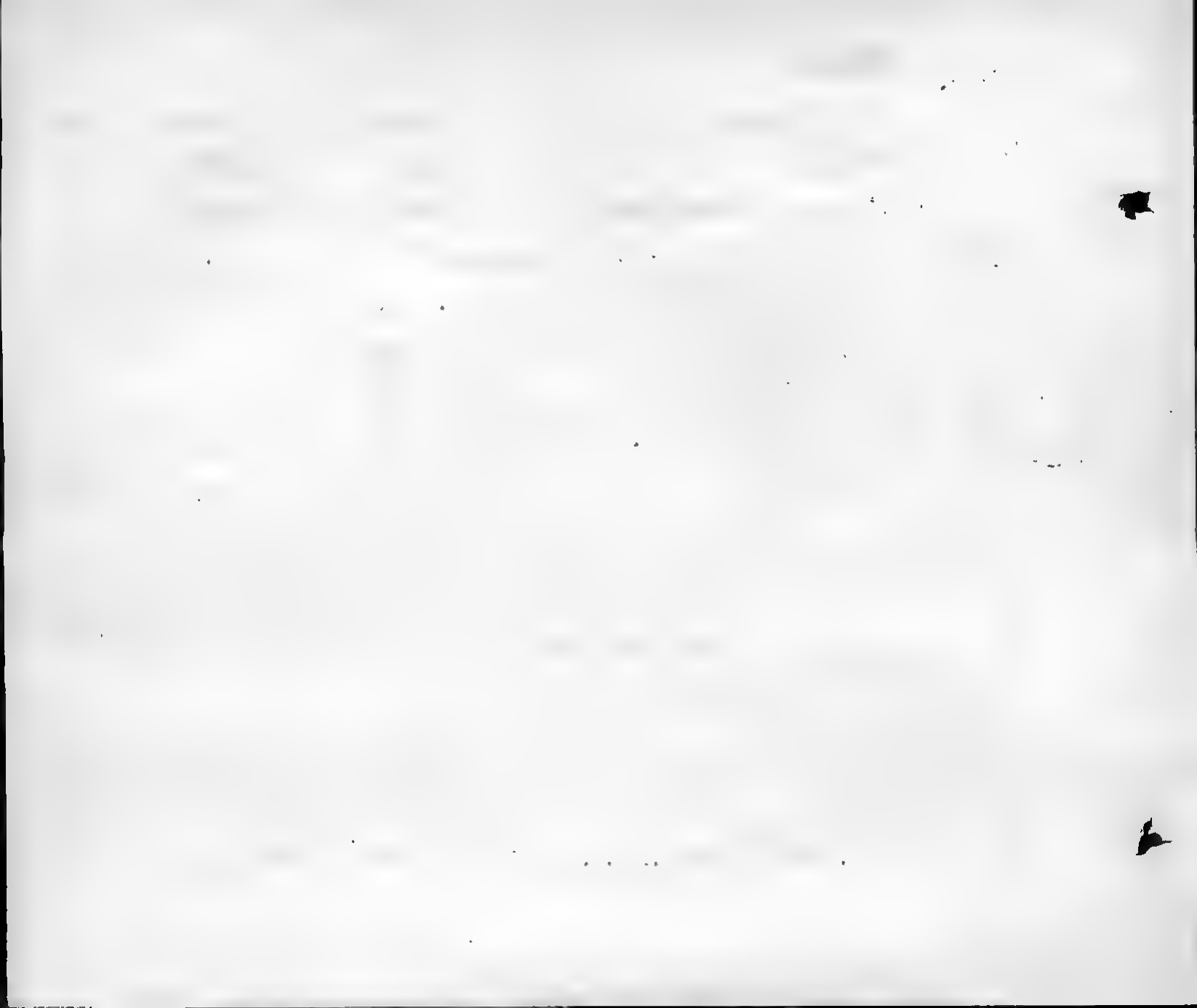
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10618

10611

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>12 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn - Hyattsville</u> d. STREET ADDRESS <u>6921 Freeport Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>H.</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>19 60</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13 Dec. 1910</u>		9. AGE (In years last birthday) <u>49</u> yrs IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>O.S. & D. Brooks Transportation</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Old Forge, Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>			
13. FATHER'S NAME <u>Hugh McDonald</u>				14. MOTHER'S MAIDEN NAME <u>Alice Cadden</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Dr. H. #2</u>				16. SOCIAL SECURITY NO <u>478-01-9228</u>		17. INFORMANT <u>Mary M. McDonald - Wife</u> Address <u>above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Pontine hemorrhage</u> <u>443x</u> DUE TO (b) <u>hypertensive intracerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>unknown</u>								INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>18 Sept. 1960</u> to <u>19 Sept. 1960</u> that (I) (we) last saw the deceased alive on <u>19 Sept. 1960</u> and that death occurred at <u>7:15A</u> from the causes and on the date stated above									
22a. SIGNATURE <u>Thomas J. Maloney</u> M.D.				22b. DATE SIGNED <u>9/19/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas Maloney, M.D.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u>				ADDRESS <u>mt. Rainier Mt</u>		25. REC'D BY REGISTRAR <u>DATE SEP 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or inhumation, and in any event within 72 hours after death.

1
10573
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>15012-54th PLACE</u>	
3. NAME OF DECEASED (Type or print) First <u>VAN</u> Middle <u>McKINSTRY</u> Last <u>McMAINS</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 6, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EDUCATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>teaching</u>	
11. BIRTHPLACE (State or foreign country) <u>Elizabeth, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Moore McMAINS</u>		14. MOTHER'S MAIDEN NAME <u>Joanna Reed.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>577-12-584</u>	
17. INFORMANT <u>Wife + daughter</u>		Address <u>5012 54th Pl. Hyatts.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Insufficiency</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>54</u> , to <u>PRESENT</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>16 Sept.</u> , 19 <u>60</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Frederick Barr</u> M.D.		ADDRESS (Street, city or town, state) <u>4500 College Ave, College Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. FREDERICK BARR, M.D.</u>		DATE SIGNED <u>20 Sept, 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>Wash 2, D.C.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE SEP 23 '60			



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0107/1500

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

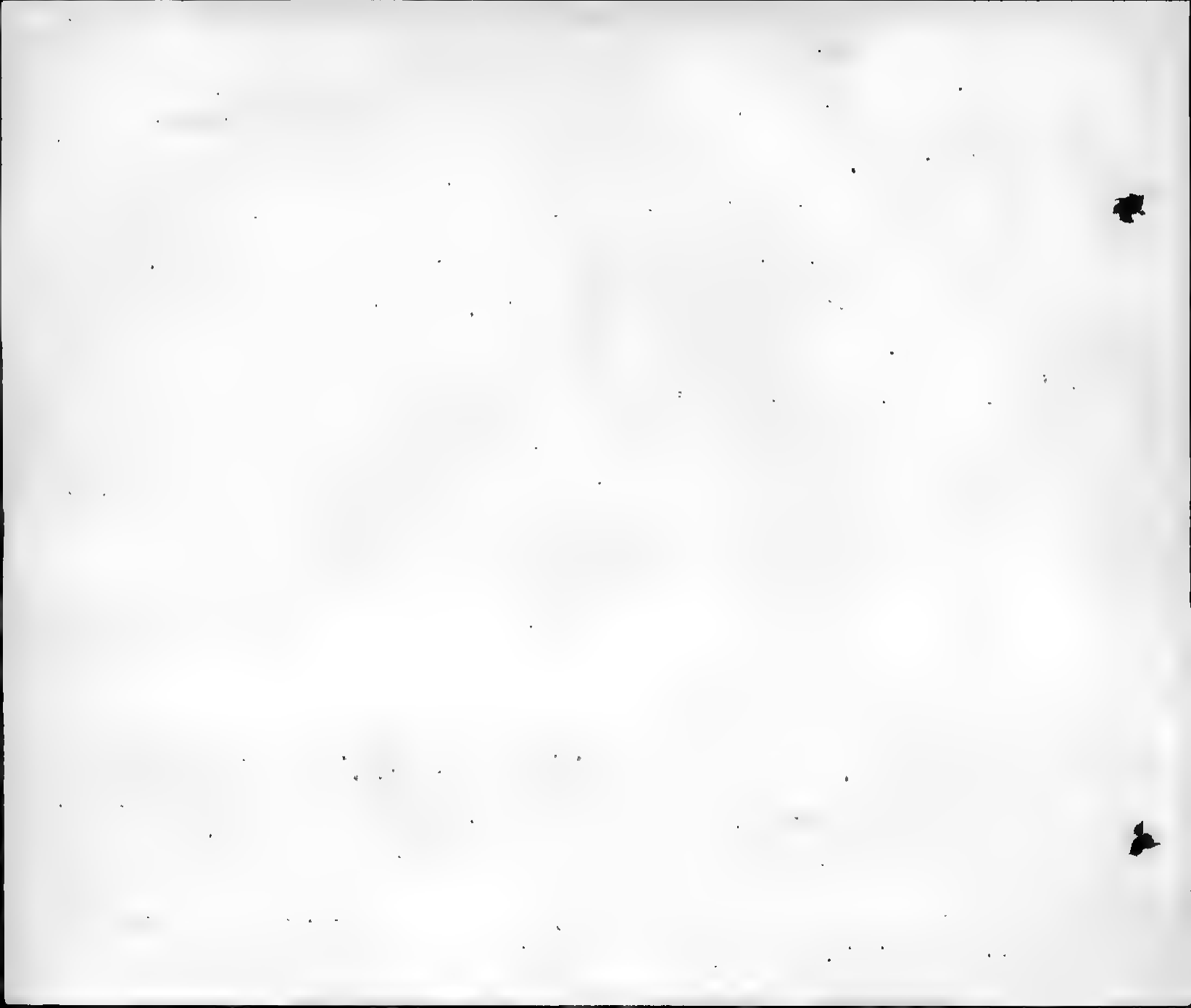
10612

CERTIFICATE OF DEATH

Reg. Dist. No

10620

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>11 Hr</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hosp.</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u> d. STREET ADDRESS <u>7607 Barto Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine S. Milburn</u>		4. DATE OF DEATH <u>9/8/60</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Manager Rooming House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Richie R. Georges, Inc.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13 FATHER'S NAME <u>Austin Cusick</u>		14 MOTHER'S MAIDEN NAME <u>Georgia Farrell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-428</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Small bowel obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>70.5</u> (b) <u>2 days</u> (c) <u>above</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Islets with two</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>8</u> p. m. <u>15</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5432 QUEENS CHAPEL Rd</u>		20f. (City or town) <u>WYATTSVILLE Md.</u> (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 7</u> , 19 <u>60</u> to <u>Sept. 8</u> , 19 <u>60</u> and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ronald S. Fleischer</u> M.D.		DATE SIGNED <u>9/4/60</u>	
PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>		<u>WYATTSVILLE Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/12/60</u>	<u>Mt. Olivet</u>	<u>Washington</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR <u>Md.</u>	24b. REGISTRAR'S SIGNATURE <u>Curtis S. Fries</u>
ADDRESS <u>Mt. Rainier</u>		DATE <u>SEP 13 '60</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

10621
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10574
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 10 years 62			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6215-41st Ave				d. STREET ADDRESS 6215-41st St Hyattsville			
3. NAME OF DECEASED (Type or print) First Middle Last Hyman Virginia Miller				4. DATE OF DEATH Month Day Year Sept 29 1960			
5. SEX F.		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1885	
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME Thomas J. Martin				14. MOTHER'S MAIDEN NAME Virginia Blake			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Bernard F. Miller 6215 41st St. Hyattsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 172 x Palmonary Edema & Congestion Heart failure DUE TO (b) Metastatic Carcinoma DUE TO (c) Carcinoma Pancreas of Uterus INTERVAL BETWEEN ONSET AND DEATH about 5 years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1958 to 9-21-60, 19 that (I) (we) last saw the deceased alive on 9-10-60 19 and that death occurred at 3:45 AM, from the causes and on the date stated above.							
22a. SIGNATURE William C. Weintraub				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9-21-60	
22c. PHYSICIAN'S NAME (Type) William C. Weintraub				22d. ADDRESS 9E Parkway Rd, Greenbelt, Md			
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF 9/23/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland Md	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Wm. Lee & Son Co 300 4th St NE Wash DC				25a. REC'D BY REGISTRAR DATE SEP 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and any event within 72 hours after death.

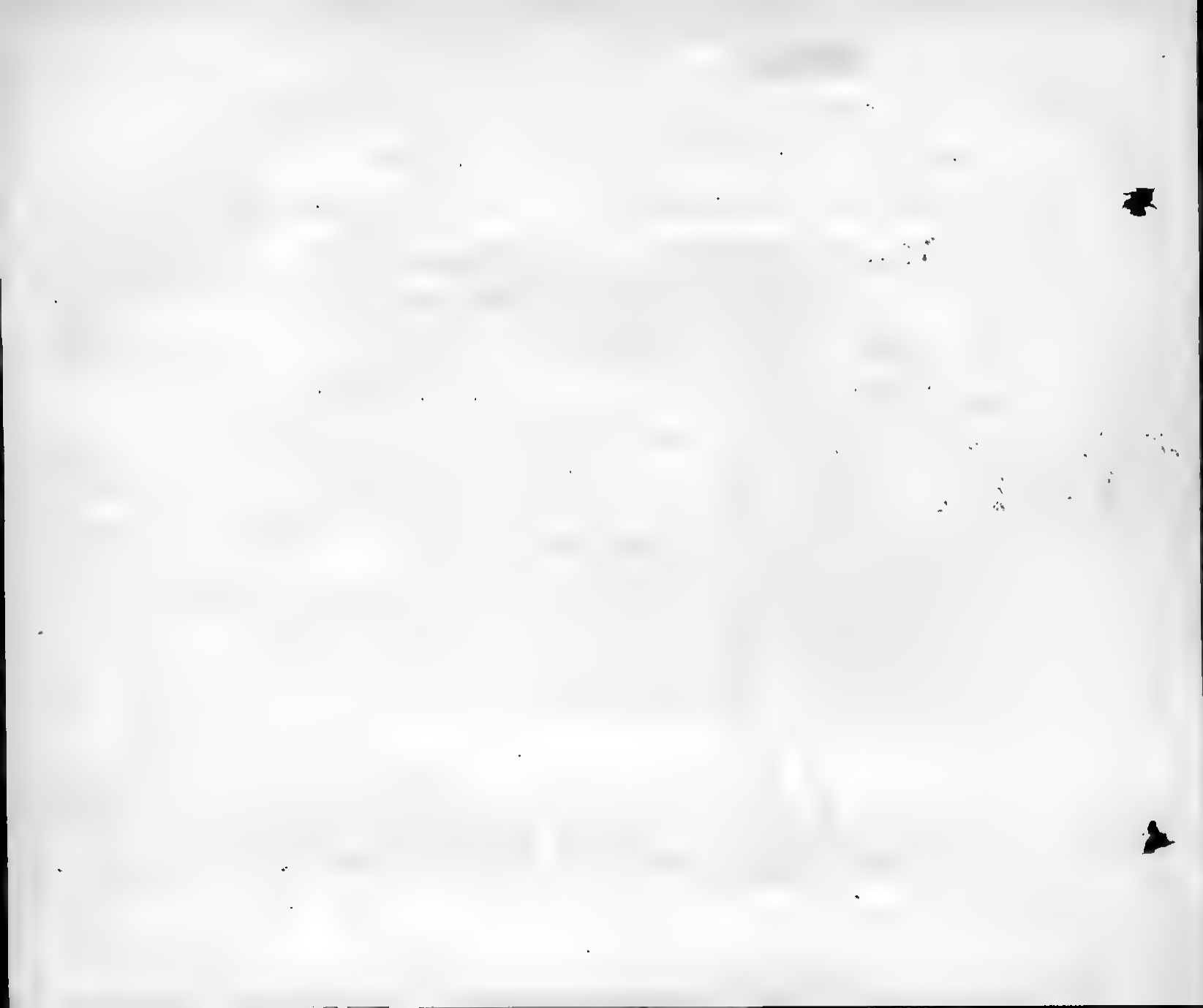
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15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10659
CERTIFICATE OF DEATH

10622

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, WASH 25, DC		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 115 DANBURY STREET, SW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Miller</i> Middle <i>Flem.</i> Last <i>Inf.</i> 4. DATE OF DEATH Month <i>Sept</i> Day <i>26</i> Year <i>1960</i>		5. SEX <i>Fem.</i> 6. COLOR OR RACE <i>Can</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>25 September 60</i> 9. AGE (In years last birthday) <i>np.</i> yrs Months Days Hours Min <i>1 1 20</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 10b. KIND OF BUSINESS OR INDUSTRY NONE 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME MARTIN MICHAEL MILLER 14. MOTHER'S MAIDEN NAME MARY RUTH SAVAGE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. N/A 17. INFORMANT <i>MARTIN M. MILLER</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory distress of newborn</i> <i>762.5</i> DUE TO (b) <i>Atelectasis, pulmonary, probable.</i> Conditions: if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH <i>1 DAY</i> <i>1 DAY</i>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pre maturity</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/> 20c. TIME OF INJURY Month, Day, Year Hour a m p m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>25 Sept</i> , 19 <i>60</i> , to <i>26 Sep 60</i> , 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>Sept 26, 1960</i> and that death occurred <i>08:35</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles B Mahon</i> 22b. PHYSICIAN'S NAME (Type) CHARLES B MAHON, CAPT USAF MC		22c. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC 22d. DATE <i>26 Sept 60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> 23b. DATE THEREOF <i>Sept. 30, 1960</i> 23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATIONAL</i> 23d. LOCATION (City, town, or county) (State) <i>ARLINGTON VA</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Kline</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> 25c. DATE SEP 28 '60	

2 - 112 XV



10660

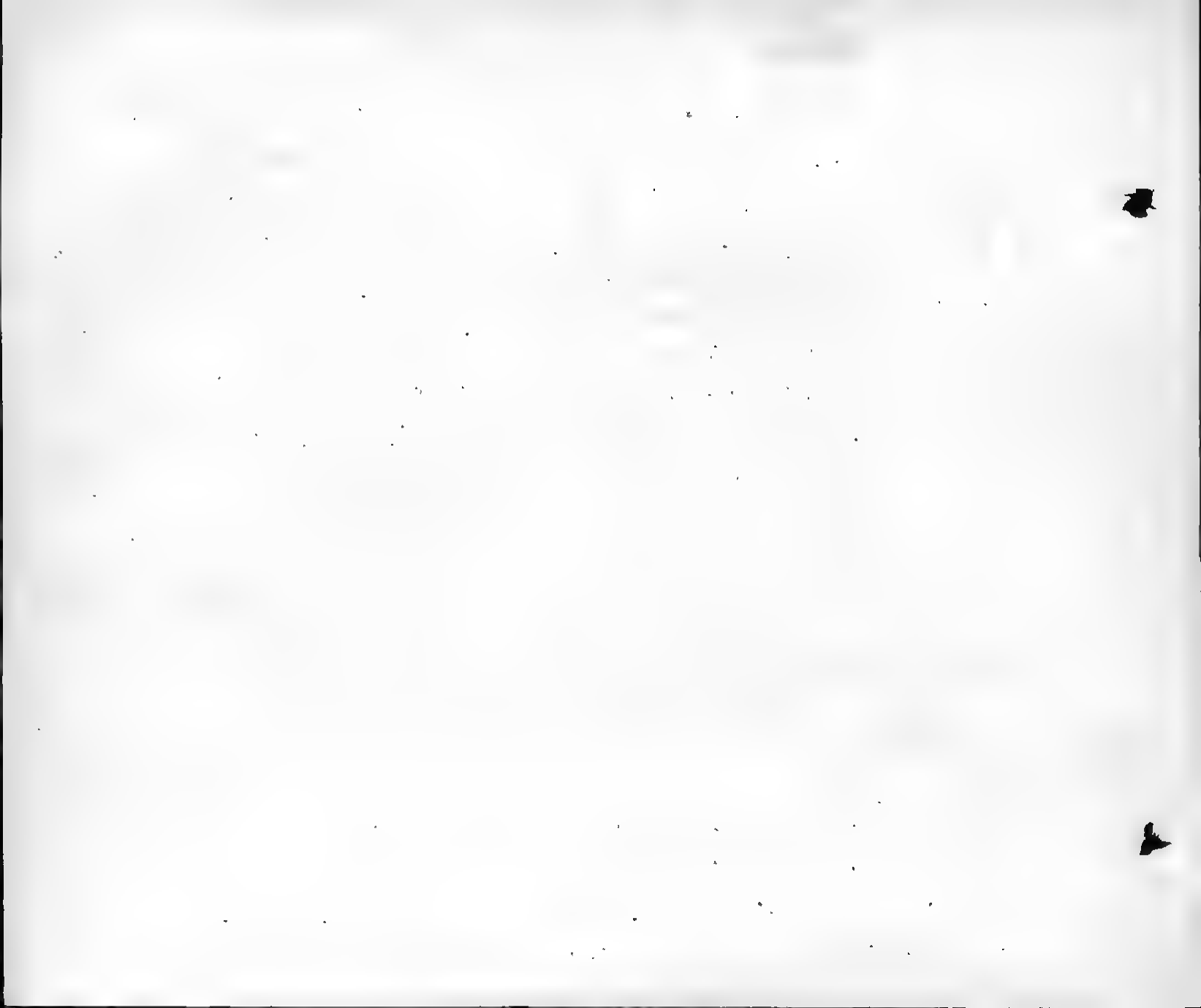
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AVONDALE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AVONDALE</u>	
c. LENGTH OF STAY IN 1b <u>6 YRS.</u>		d. STREET ADDRESS <u>2102-QUEENS CHAPEL RD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2102-QUEENS CHAPEL RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE KEY MULVIHILL</u>		4. DATE OF DEATH Month Day Year <u>9-4-1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1912</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WASH. GAS. CO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ASS'T - SUP.</u>	11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN MULVIHILL</u>	
14. MOTHER'S MAIDEN NAME <u>MARY CURTIN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.II</u>	
16. SOCIAL SECURITY NO. <u>577 077536</u>		INFORMANT Address <u>MARGARET MULVIHILL - WIFE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 yrs +</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>60</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>3501 Hamilton St Hyte</u> <u>9/4/60</u> ACTUAL SIGNATURE <u>Frank M. Trozzo Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>FRANK M. TROZZO JR.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-7-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>BRAIDENSBURG MO.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hamilton</u> ADDRESS <u>-3831-GR. AVE NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Robert S. [illegible]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

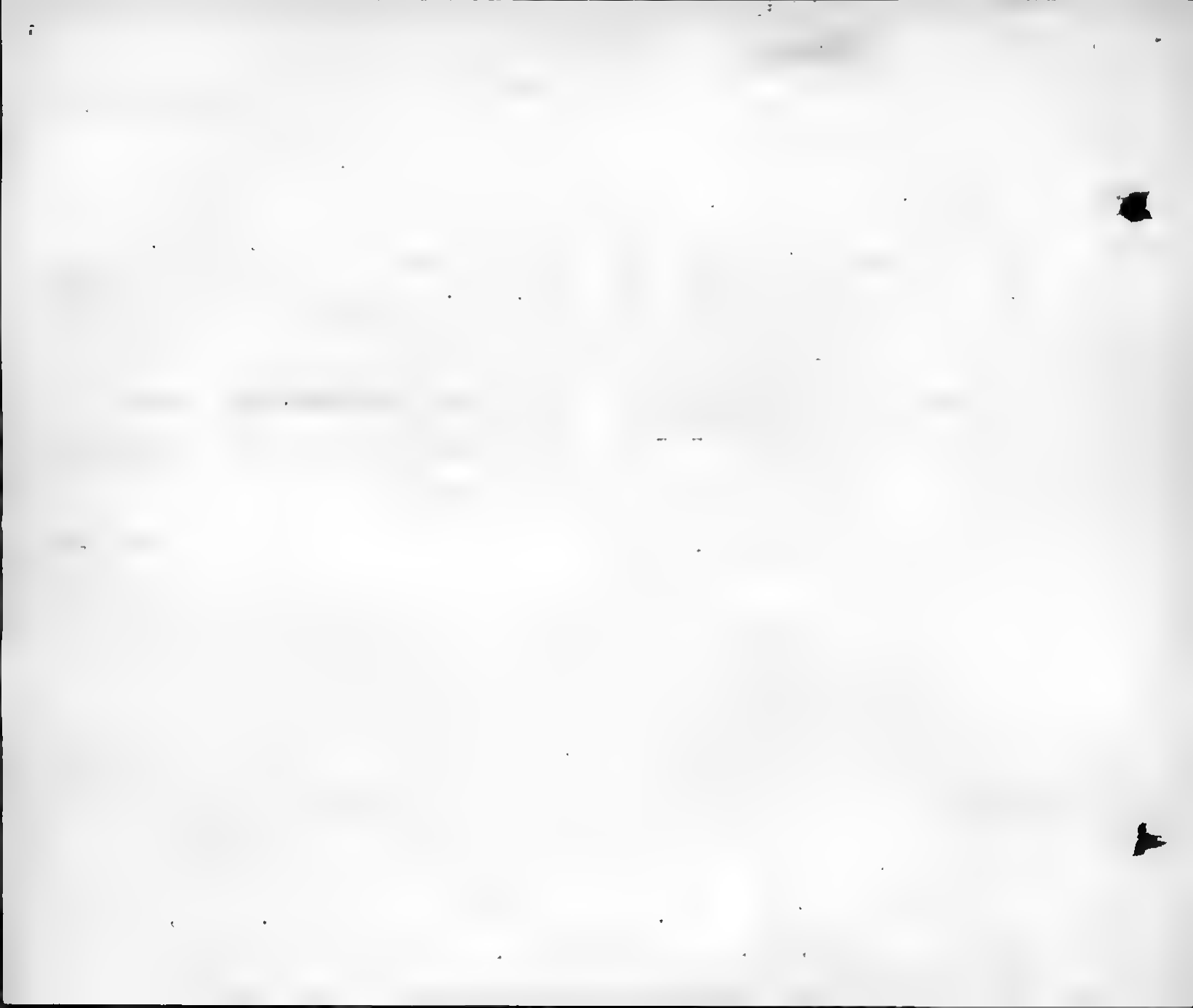
10661

CERTIFICATE OF DEATH

Reg. Dist. No.

10624

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ADELPHI</u>				c. LENGTH OF STAY IN 1b <u>5 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PAINT BRANCH NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLOTTE</u> First <u>Haywood</u> Middle <u>MURRAY</u> Last				4. DATE OF DEATH <u>SEPT.</u> Month <u>11</u> Day <u>1960</u> Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 21, 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEPT. STORE BUYER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>			
11. BIRTHPLACE (State or foreign country) <u>MAINE</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CHARLES E. MURRAY</u>				14. MOTHER'S MAIDEN NAME <u>MARY HAYWOOD</u> HAYWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>012-10-4152</u>			
17. INFORMANT <u>PAINT BRANCH NURSING HOME RECORDS</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>Chronic cardiac decompensation</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u> <u>Many years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1958</u> , 19 <u> </u> , to <u>Sept. 11</u> , 1960, that I last saw the deceased alive on <u>Sept. 9</u> , 1960, and that death occurred at <u>5:45</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>9301 Coleridge Rd., Silver Spring, Md.</u> DATE SIGNED <u>Sept. 11, 1960</u>							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D. 9301 Coleridge Rd., Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				22b. DATE THEREOF <u>9/14/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>				22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Pimphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 16 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							



10662

CERTIFICATE OF DEATH

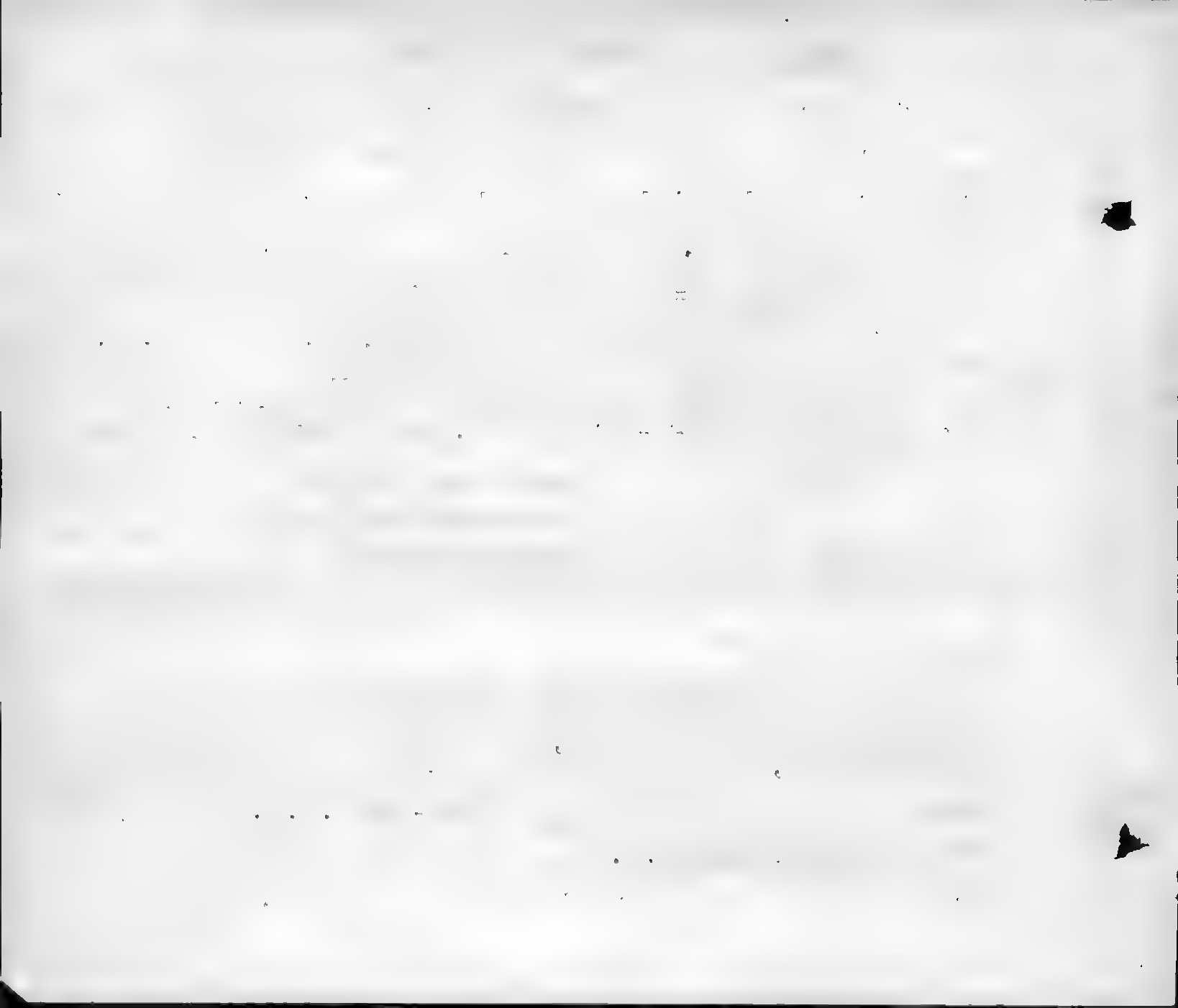
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3104--Parkway Terr. Dr SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALGINDIA Middle N. Last MYER		4. DATE OF DEATH Month Sept. 11 Day 19 Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1883
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Norris		14. MOTHER'S MAIDEN NAME Susan Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Austin H. Myer		Address 735 Wood Hill Rd. Fairfax Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 1956 to Sept. 11, 1960 that I last saw the deceased alive on 7/27/60 19 and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney W. Lowry		ADDRESS (Street, city or town, state) 7200-MARLBORO PIKE S.E. WASH. D.C. DATE SIGNED 9/11/60	
PHYSICIAN'S NAME (Type) Sidney W. Lowry M. D.		7200 Marlboro Pike S.E. Wash. 28, D.C.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 13-60	22c. NAME OF CEMETERY OR CREMATORY Wilbur Cemetery	22d. LOCATION (City, town, or county) (State) Wilbur, West Va.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1661--Good Hope Rd SE Washington 20 DC		24a. REC'D BY REGISTRAR DATE SEP 13 '60	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

* * * * *



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10627

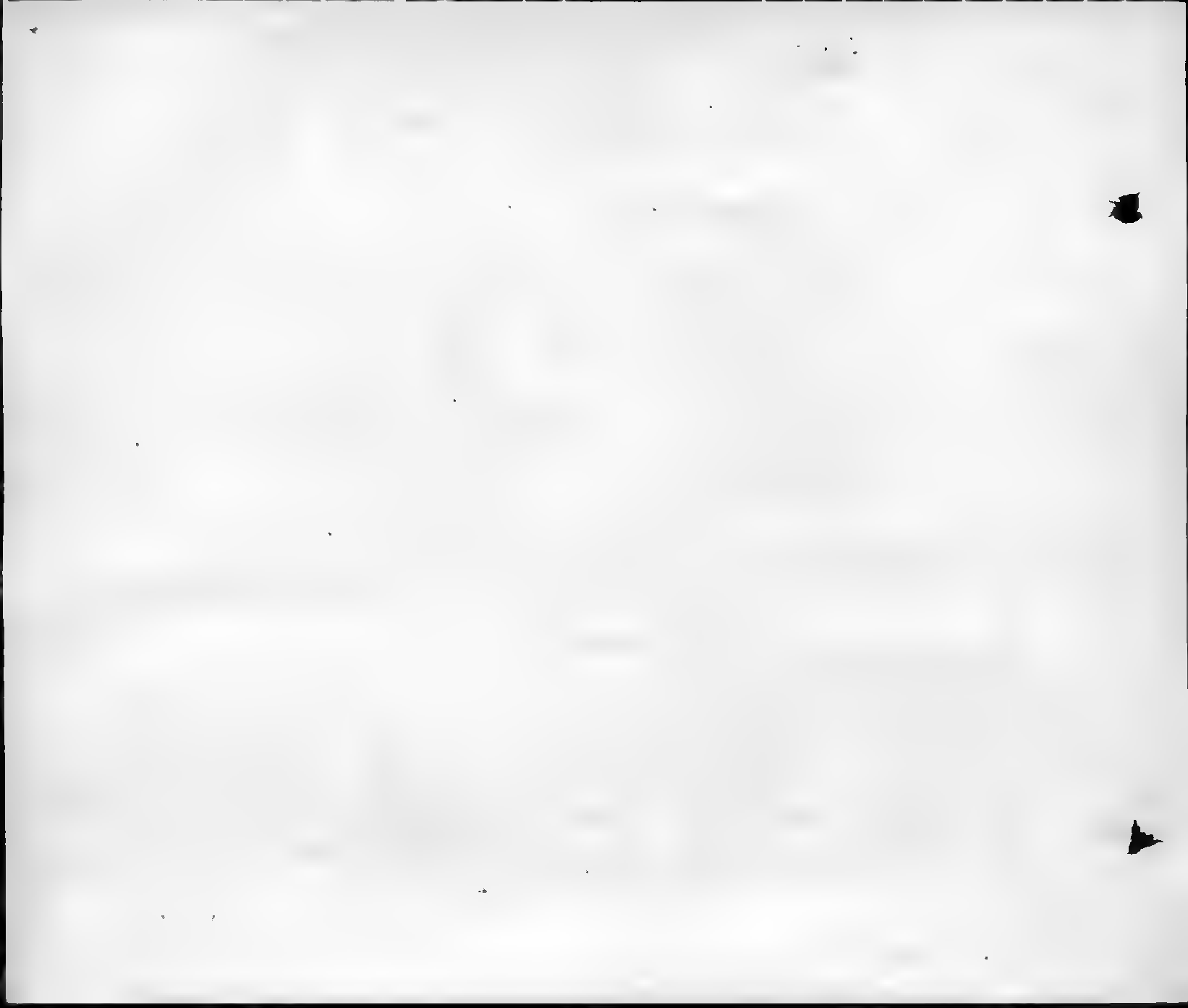
10614

1 PLACE OF DEATH a COUNTY <u>Prince Georges</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Pr. Georges</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c LENGTH OF STAY IN 1b <u>Hyattsville</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pr. Georges' General</u>				d STREET ADDRESS <u>16003 43rd Ave</u>			
3 NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>WALTER</u> Last <u>PERTLY</u>				4 DATE OF DEATH Month <u>SEP</u> Day <u>6</u> Year <u>1960</u>			
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 28, 1901</u>		9 AGE (In years last birthday) <u>59</u> yrs	10 IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government Clerk</u>		11 BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13 FATHER'S NAME <u>David H Oertly</u>				14 MOTHER'S MAIDEN NAME <u>Mary A Bowen</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO. <u> </u>		17 INFORMANT <u>Mildred C Oertly</u> Address <u>Hyattsville, Md.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the body of the pancreas</u> DUE TO (b) <u>Carcinoma of the body of the pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f (City or town) (County) (State) <u> </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>JAN 1, 1954</u> to <u>SEP 6, 1960</u> that (I) (we) last saw the deceased alive on <u>9/6/60</u> and that death occurred <u>8:45 PM</u> from the causes and on the date stated above.							
22a SIGNATURE <u>Samuel J. N. Sugar</u>				22b ADDRESS <u>4300 Kaywood Dr., Mt Rainier</u>		22c DATE SIGNED <u>SEP 6 1960</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>9/9/60</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				25a REC'D BY REGISTRAR DATE <u>SEP 9 '60</u>		25b REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

(M)

(I)

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10615

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roger's Heights						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General					d. STREET ADDRESS 5306 Hamilton Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Josephine Middle M. Last Patten					4. DATE OF DEATH Month September Day 29 Year 19 60						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-96		9. AGE (in years last birthday) 64 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maine			12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME Ezekial Jackson					14. MOTHER'S MAIDEN NAME Carrie Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none		17. INFORMANT Montford E Patten Roger Heights, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli DUE TO (b) Carcinomatosis DUE TO (c) Carcinoma of the head of the Pancreas CONDITIONS, if any which gave rise to immediate cause (a), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis										INTERVAL BETWEEN ONSET AND DEATH 24 hours months months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 9/26 19 60 , to 9/29 19 60 that (I) (we) last saw the deceased alive on 9/29 19 60 , and that death occurred at 3:25 P.M. from the causes and on the date stated above											
22a. SIGNATURE Norman Donat Comeau					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/29/60				
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU					22d. ADDRESS 3503 PENNY ST. MT PAINIER MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/30/60		23c. NAME OF CEMETERY OR CREMATORY George Washington			23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 3 '60		25b. REGISTRAR'S SIGNATURE Conrad S. Frank		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

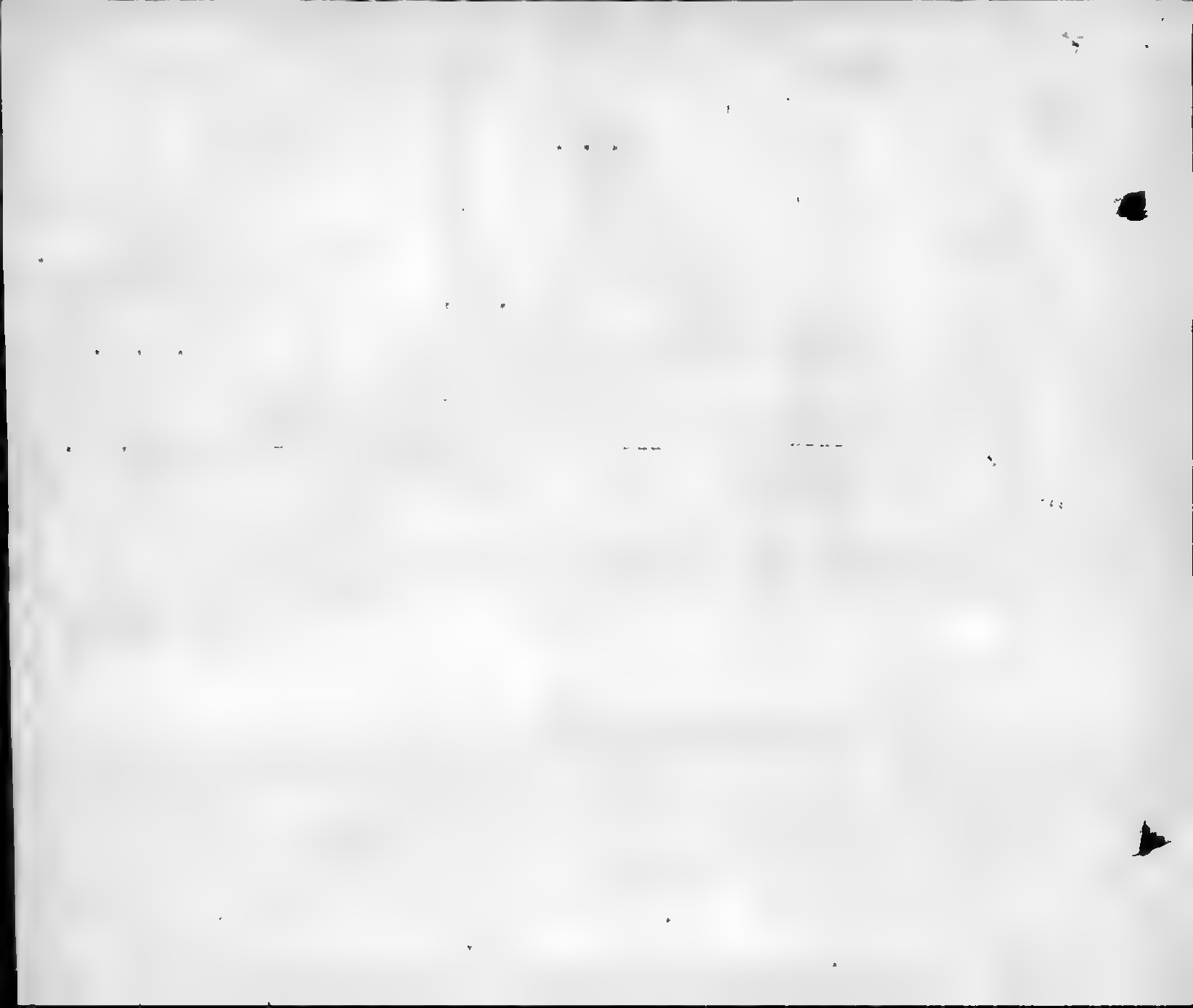
10629

Reg. Dist. No.

10616

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges' General Hospital				e. STREET ADDRESS 1 -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Coleman Last Payne				4. DATE OF DEATH Month September Day 22 Year 19 60.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 14, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroads	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Fred Foote Payne		14. MOTHER'S MAIDEN NAME Mary-(last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Hilda Gertrude Payne-Cheltenham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH inst</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis, Arteriosclerosis generally							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> no				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dayton Swack				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) DAYTON SWACK				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home—Upper Marlboro;				24c. REC'D BY REGISTRAR DATE SEP 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Farris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



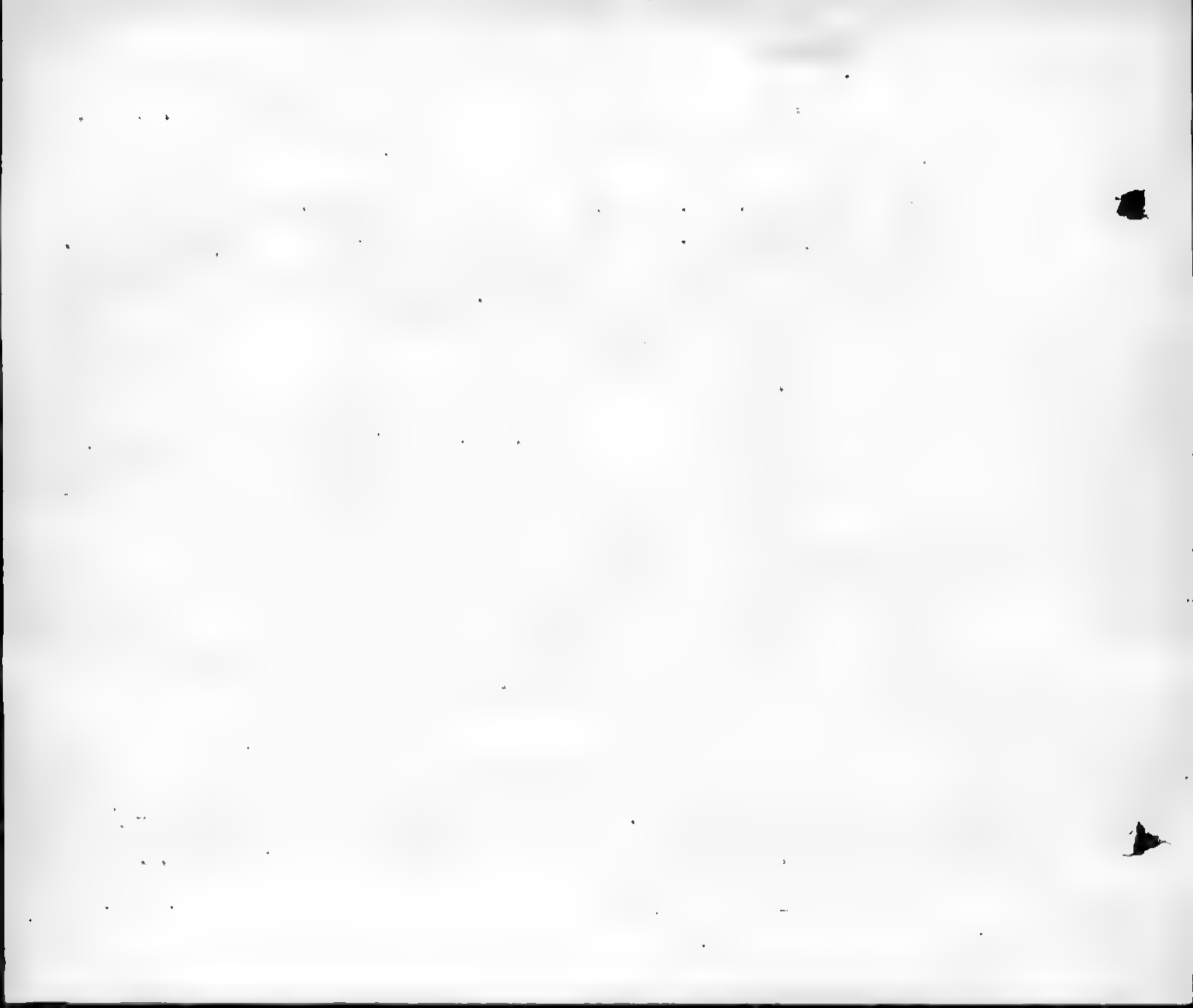
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10663
CERTIFICATE OF DEATH

10630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Prince Geo. Gen. Hospital		e. STREET ADDRESS 5200--53rd Ave S.E.	
3. NAME OF DECEASED (Type or print) First ANTONIA Middle M. Last PINTO		4. DATE OF DEATH Month Sept. Day 15th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8th 1891
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Joseph Cestone		14. MOTHER'S MAIDEN NAME Mary Simone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Domenic Pinto 5200-53rd Ave Camp Springs Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-2, 1952 to 9-15, 1960 ; that I last saw the deceased alive on 9-10, 1960 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank S. Pellegrini M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3409 Ala Ave SE 9-15-60	
PHYSICIAN'S NAME (Type) Frank S. Pellegrini		3409--Alabama Ave SE Was h. DC	
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 9-19-1960	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Bladensburg Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Senimus Bro.		ADDRESS 1661--Good Hope RD SE Washington 20 DC	24a. REC'D BY REGISTRAR DATE SEP 19 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Filing 15-25-60 et

Reg. Dist. No.

10631

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1001-64 PL</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH POTEAU</u>		4. DATE OF DEATH <u>Sept. 30</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Age: <u>72</u> Yrs <u>3</u> Mo <u>17</u> Days <u>11</u> Hrs <u>11</u> Min <u>11</u> Sec <u>11</u> AM
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clashon Pateat</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-12-2547</u>	
17. INFORMANT <u>Julia Pateat</u>		Address <u>1001-64 PL Cedar Hts Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 434-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic heart failure</u> (a), stating the underlying cause last. DUE TO (c) <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fat</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY <u>no</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED <u>no</u> While at work <input type="checkbox"/> While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>P</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O. Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct-4/60</u>		22b. DATE THEREOF <u>Oct-4/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>Lanham, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>AS Washington Sons</u>		ADDRESS <u>4925-Heene Cr.-NE</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

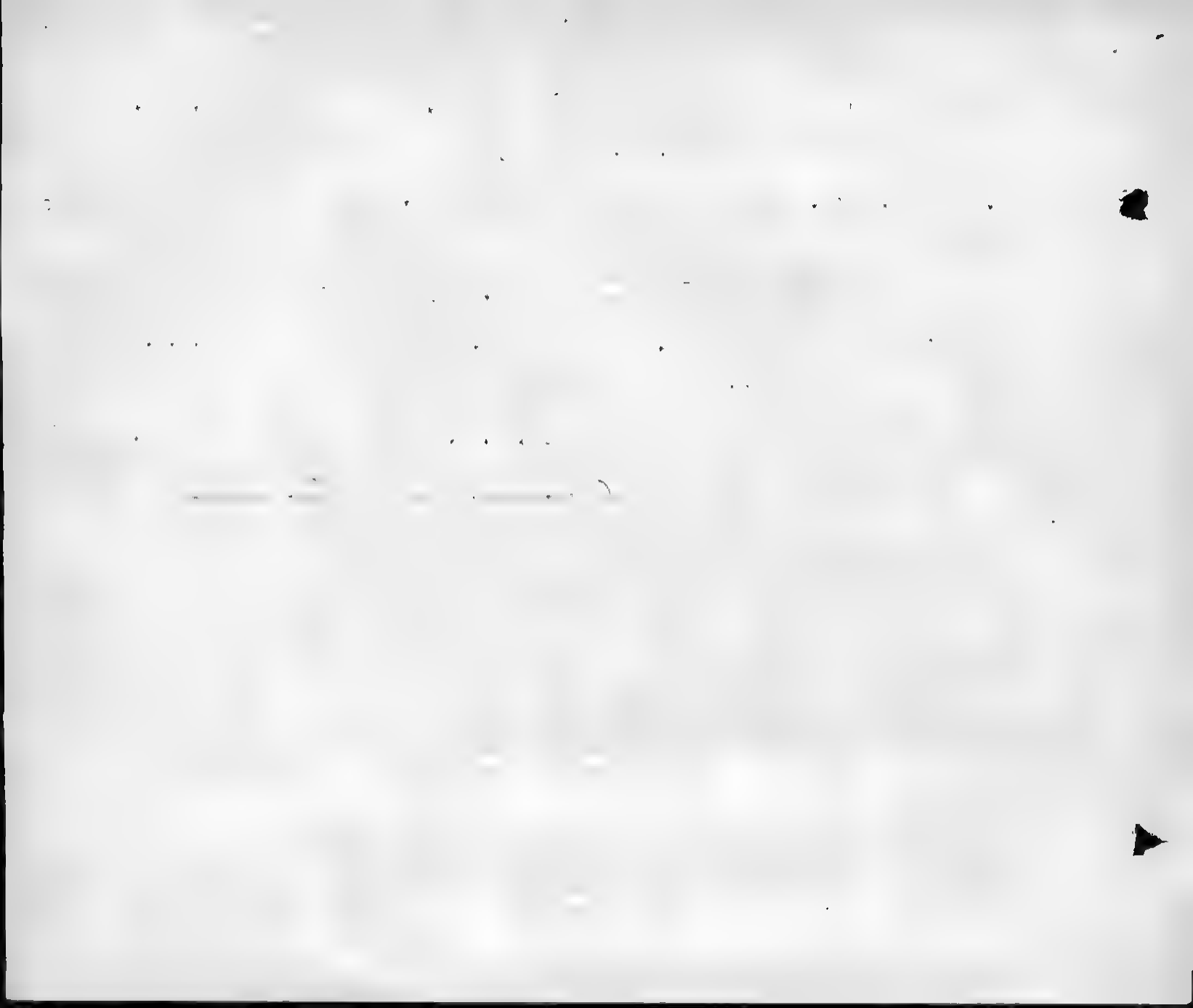
10632

10618

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A.			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans d. STREET ADDRESS Bryans Rd., Box # 163 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First THOMAS Middle LEROY Last PULLIAM			4. DATE OF DEATH Month Sept Day 24 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Dec. 1935	9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto.		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME Harry Clay Pulliam			14. MOTHER'S MAIDEN NAME Katie Dudley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. T. L. Pulliam (Wife) Address Same Add. As # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Contusion & Laceration DUE TO Fracture Skull, Fractured Ribs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Fracture Skull, Fractured Ribs DUE TO Fracture Skull, Fractured Ribs					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - Thrown from a car			
20c. TIME OF INJURY Month, Day, Year 11/23/59-23 1960		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Accident	
20f. City or town Pleasant		20g. County Pr. Geo.		20h. State Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 9-27-60		22c. NAME OF CEMETERY OR CREMATORY Bumpy Oak
22d. LOCATION (City, town, or county) Pomonkey Md.			22e. State Md.		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, WADDORE, Md.			24a. REC'D BY REGISTRAR OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
15M 9/59

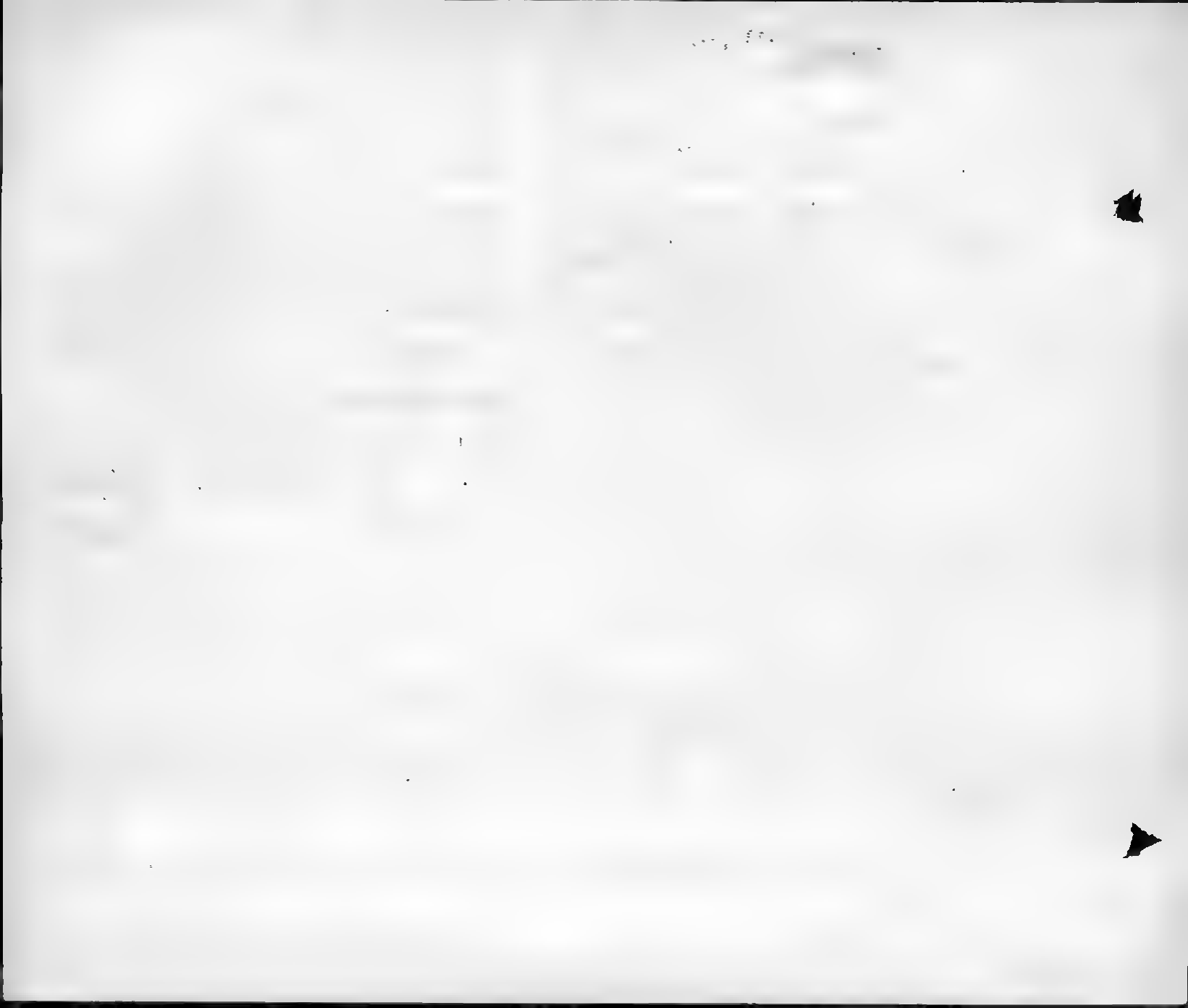
10664

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8 Sept 60
10633

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 3 hrs 28 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, WASH 25, DC		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY CALVERT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS d. STREET ADDRESS BOX 215 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROBERT Middle BRADLEY Last PRATER		4. DATE OF DEATH Month Sept Day 8 Year 19 60	
5. SEX male	6. COLOR OR RACE car	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 September 1960
9. AGE (In years lost birthday) yrs 3		10. AGE (In years lost birthday) Months 3 Days 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME PAUL STEVENS PRATER		14. MOTHER'S MAIDEN NAME MARY LEE CARR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT NEWBORN'S RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ateletasis of lungs 762.5 DUE TO 3 hrs Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO 3 hrs 28 min (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 8 Sept 19 60 to 8 Sept 19 60 that (I) (we) lost saw the deceased alive on 8 Sept 19 60 and that death occurred at 8:30A from the causes and on the date stated above			
22a. SIGNATURE Arnold A Abramo 22c. PHYSICIAN'S NAME (Type) ARNOLD A ABRAMO CAPT USAF MC		22b. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Sept 12, 1960		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Funeral Home, 816 4th St NE		25a. REC'D BY REGISTRAR DATE SEP 13 1960	
25b. REGISTRAR'S SIGNATURE Robert S. Hulse			

20 50255XV3



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10619

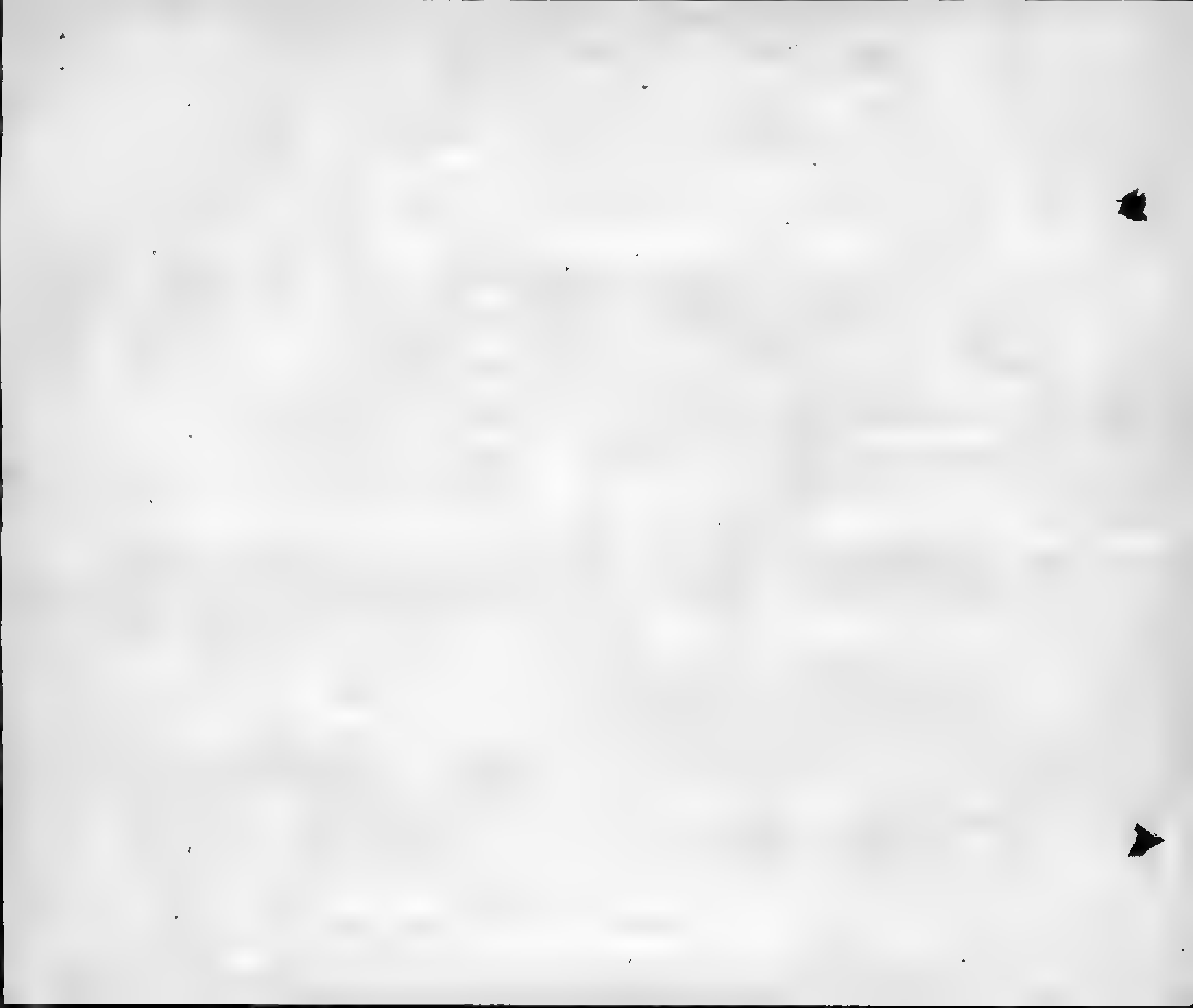
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10634

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b D O A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood Md			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3704 Taylor Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William M. Reamy				4. DATE OF DEATH Month Day Year Sept 1, 19 60-			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 23, 1896		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Town of Brentwood Md		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alex Reamy				14. MOTHER'S MAIDEN NAME Maggie Reamy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 218 03 7091		17. INFORMANT Alice Reamy Address Brentwood, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Surgical Shock</u> DUE TO <u>Guns shot wound of abdomen</u> Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO							INTERVA. BETWEEN ONSET AND DEATH <u>inst</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Brentwood		(County) Prince George's		(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) DAYTON O WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/3/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland				24a. REC'D BY REGISTRAR DATE SEP 6 '60		24b. REGISTRAR'S SIGNATURE Arthur L. House	
22d. LOCATION (City, town, or county) Colmar Manor, Md.				22e. (State) Md.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

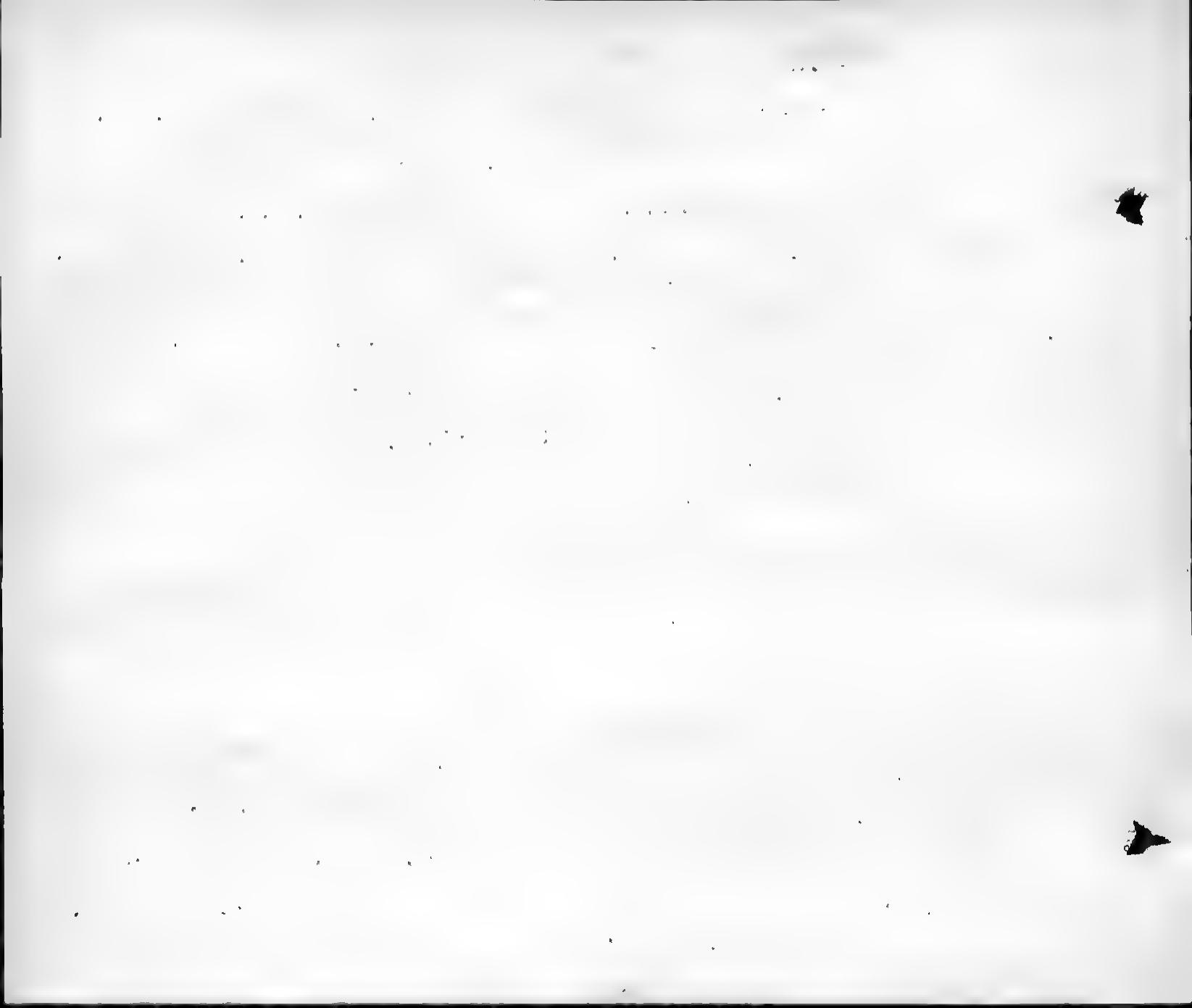
10665

CERTIFICATE OF DEATH

Reg. Dist. No.

10635

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Foote				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Foote			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4338--Pates Dr. S.E.				d. STREET ADDRESS 4338--Pates Dr. S.E.			
3. NAME OF DECEASED (Type or print) First ALMA Middle E. Last ROSENBALM				4. DATE OF DEATH Month Sept. Day 15th Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1903	9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George D. Gray				14. MOTHER'S MAIDEN NAME Easter Jane Hager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---		INFORMANT Address Alexander D. Rosebalm 4338--Pates Dr. SE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cholera 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11/31 , 19 60 , to 7/15/60 , 19 60 , that I last saw the deceased alive on 7/13/60 , 19 60 , and that death occurred at 1:30 A.M. from the causes and on the date stated above							
ACTUAL SIGNATURE Lewis Parker		M.D. 5241 St. Barnabas Rd. S.E. Wash. 21 DC		DATE SIGNED SEP 19 1960			
PHYSICIAN'S NAME (Type) Lewis Parker		5241 St. Barnabas Rd S.E. Wash. 21 DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-60		22c. NAME OF CEMETERY OR CREMATORY Monte Vista		22d. LOCATION (City, town, or county) (State) Bluefield West Va	
23. FUNERAL DIRECTOR'S SIGNATURE Sammons Bro.				ADDRESS 1661--Good Hope Rd., SE Washington 20 DC		24a. REC'D BY REGISTRAR SEP 19 1960	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10666
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
item 14 Form 719-1-60 et
CERTIFICATE OF DEATH

10636
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (RURAL) c. LENGTH OF STAY IN TB 34 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS, ANDREWS AFB,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE (DISTRICT OF COLUMBIA) b. COUNTY MD. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 6106 Bock Road SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First RUE Middle F Last SCARBOROUGH		4. DATE OF DEATH Month SEPT Day 1 Year 1960				
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 DECEMBER 1903	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILITARY SERVICE		10b. KIND OF BUSINESS OR INDUSTRY MILITARY SERVICE		11. BIRTHPLACE (State or foreign country) ARKANSAS		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILBUR SCARBOROUGH		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 4024-14-3785		17. INFORMANT FRANCES SCARBOROUGH Address SAME AS #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Increased Intracranial Pressure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Brain left cerebral hemisphere</i> DUE TO (c) <i>Carcinoma of the lung</i>						INTERVAL BETWEEN ONSET AND DEATH 27 Aug 60 April 60 Mar 60
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 16 MAR., 1960, to 1 SEPT., 1960, that I last saw the deceased alive on 1 SEPT., 1960, and that death occurred at 2:00 P. M. from the causes and on the date stated above.						
ACTUAL SIGNATURE Andrew W. Butchko		ADDRESS (Street, city or town, state) M.D. USAF Hq Andrews		DATE SIGNED 1 Sept 60		
PHYSICIAN'S NAME (Type) ANDREW W BUTCHKO, CAPT USAF (MC) ANDREWS AIR FORCE BASE, WASH 25, DC						
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
161-100	SEP-6-1960	Arlington National		Arlington VA.		
23. FUNERAL DIRECTOR'S SIGNATURE Kirkwood Funeral Home		ADDRESS 816 H. St. NE		24a. REC'D BY REGISTRAR DATE SEP 6 '60		
				24b. REGISTRAR'S SIGNATURE C. L. H. H.		



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10635 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>IOWA</u> b. COUNTY <u>NEW HAMPTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>NEW HAMPTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		d. STREET ADDRESS <u>1515 STRATHMORE ST FALL CH. VA.</u>	
3. NAME OF DECEASED (Type or print) <u>NELLIE B. Schnurr</u>		4. DATE OF DEATH <u>September 28 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 13, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM SCHUMACKER</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA HOWARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>MANY YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-12</u> , 19 <u>60</u> to <u>9-28</u> , 19 <u>60</u> that I last saw the deceased alive on <u>9-27-60</u> , 19 <u>60</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u> M.D.		ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u> DATE SIGNED <u>9/28/60</u>	
PHYSICIAN'S NAME (Type) <u>JESSE C. Coggins</u>		<u>LAUREL MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cem</u>	22d. LOCATION (City, town, or county) (State) <u>New Hampton Iowa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. S. Sons</u>		ADDRESS <u>300 H St NE</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>SEP 30 '60</u>			

(M)

01X

1931

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used for burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Reg. Dist. No. 10638

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 1/2 Hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SALLY T SHIPP		4. DATE OF DEATH Sept. 3 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-97
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Golben		14. MOTHER'S MAIDEN NAME Mary Jane Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital record		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO (b) Perforated sigmoid Colon DUE TO (c) Diverticulitis Complication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE DAYTON O WATKINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '60	
		24b. REGISTRAR'S SIGNATURE Charles S. Evans	



may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

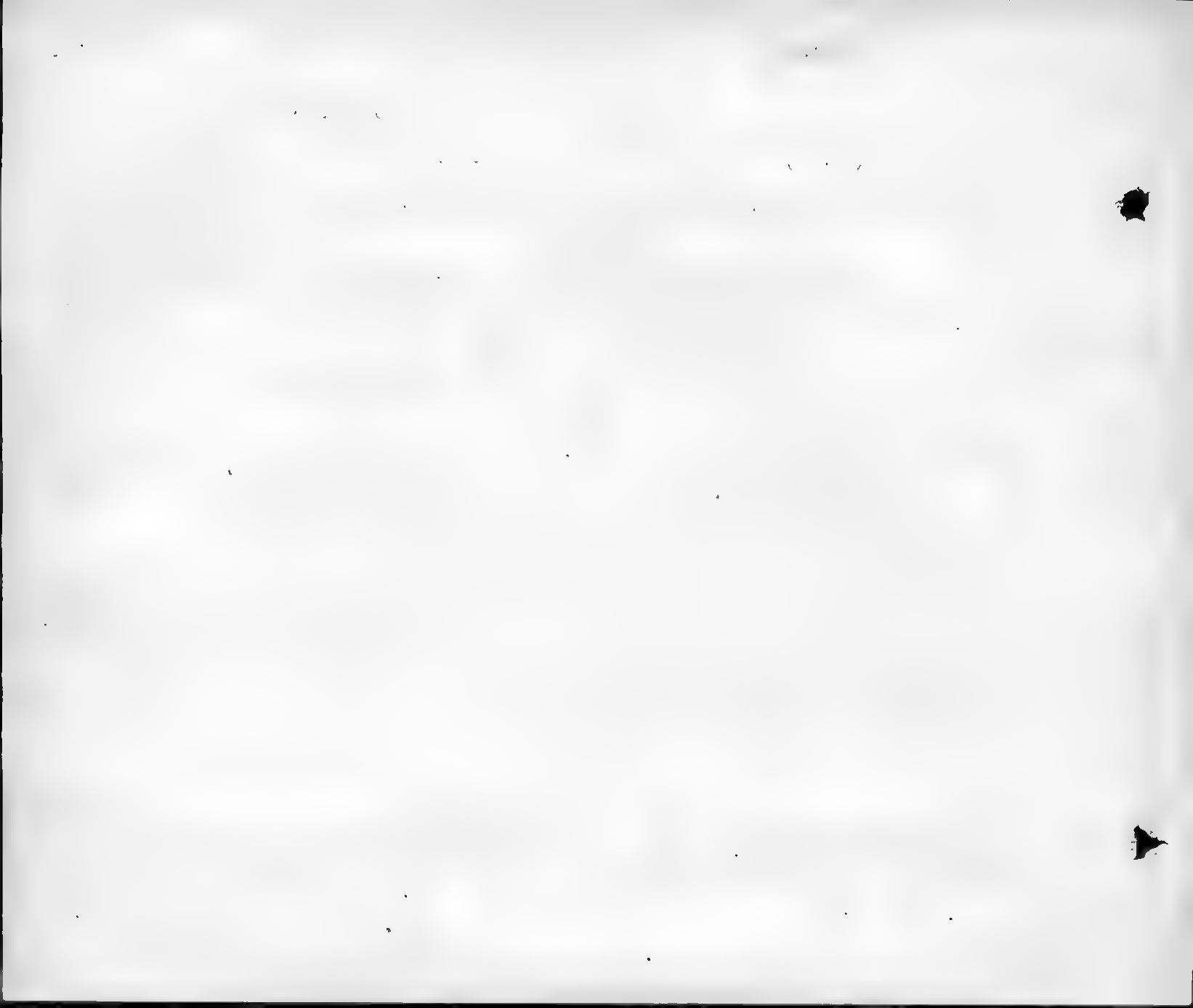
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10667

10639

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived (If institution Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS(RURAL)				c. LENGTH OF STAY IN 1b 6 1/2 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS, ANDREWS AFB				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC			
f. STREET ADDRESS 3910-4th Street SE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sisson, male inf First Middle Last				4. DATE OF DEATH Month SEPTEMBER Day 19 Year 19 60			
5. SEX MALE		6. COLOR OR RACE Can		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 SEP 60	
9. AGE (In years last birthday) Se 1000000		10. IF UNDER 1 YEAR Months Days Hours 6 30		11. IF UNDER 24 HRS Months Days Hours 6 30		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA				10b. KIND OF BUSINESS OR INDUSTRY NA			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ROBERT L SISSON				14. MOTHER'S MAIDEN NAME LINDA CAROL COKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO (If yes, give war or dates of service) NA		17. INFORMANT NONE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776X Prematurity - Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 1/2 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 Sept. 1960 to 19 Sept. 1960 , that (I) (we) last saw the deceased alive on 19 Sept 1960 and that death occurred at 10 PM from the causes and on the date stated above.							
22a. SIGNATURE Charles B Mahon				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 19 AUGUST 1960	
22c. PHYSICIAN'S NAME (Type) CHARLES B MAHON CAPT USAF MC				22d. ADDRESS USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Sept 20 - 60		23c. NAME OF CEMETERY OR CREMATORY Eedar Hill		23d. LOCATION (City town or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Seminars Brothers 1661 9th Hope Rd				25a. REC'D BY REGISTRAR SE		25b. REGISTRAR'S SIGNATURE Charles S. Hines	

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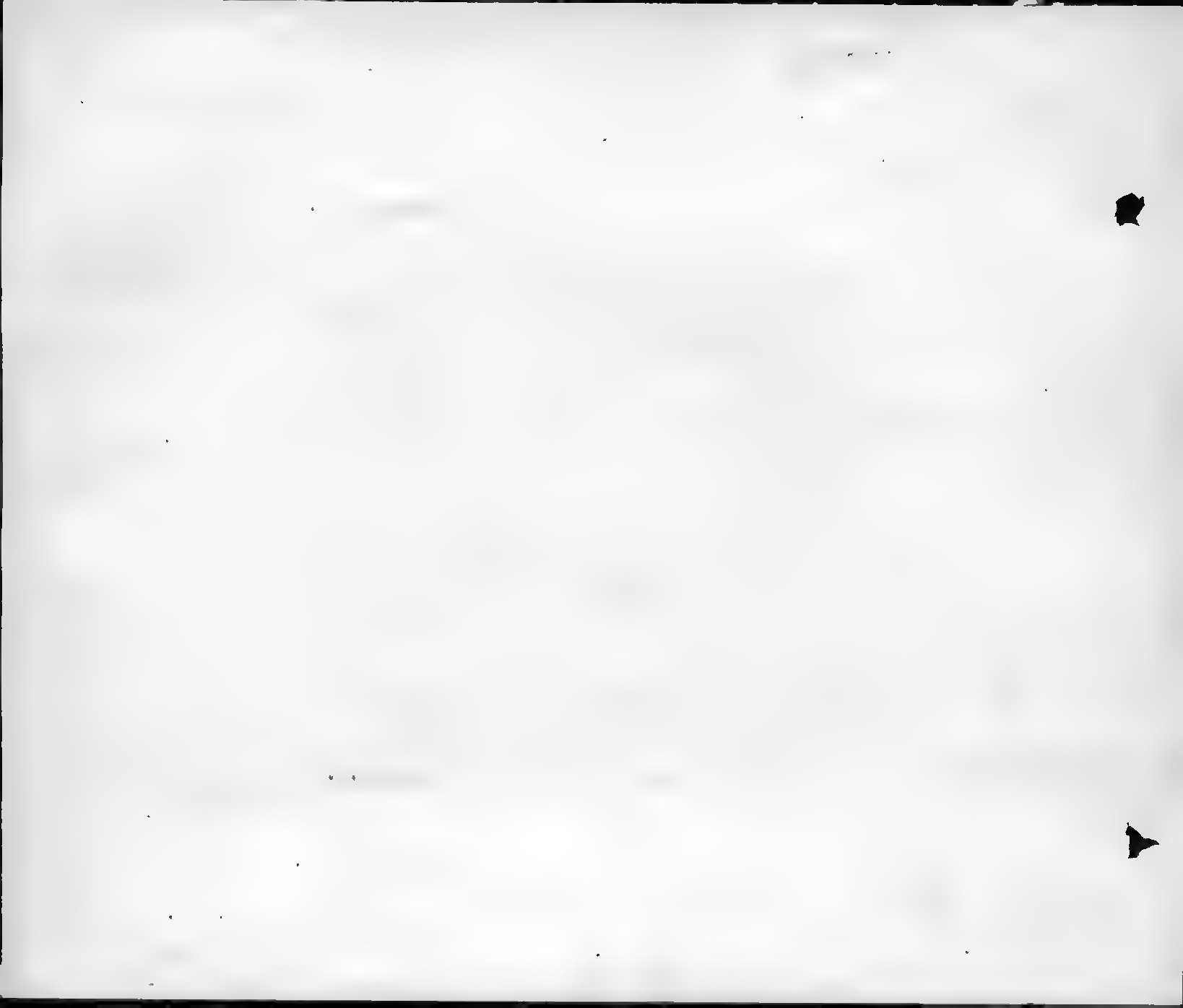
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10621
CERTIFICATE OF DEATH

10640

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		d. STREET ADDRESS 4203 Gallatin St	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Murray Smith		4. DATE OF DEATH Month Day Year September 17 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-86
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Buyer for Seed Company		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Basil Smith		14. MOTHER'S MAIDEN NAME Frances Chilcoate	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Leonard M Smith		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) cerebral arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 12-14	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 17, 1960, to Sept 18, 1960, that (I) (we) last saw the deceased alive on Sept 17, 1960, and that death occurred at 5:05 PM on the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED Sept 18, 1960	
22c. PHYSICIAN'S NAME (Type) Til Bergman		22d. ADDRESS Hyattsville Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE SEP 19 '60	
ADDRESS Hyattsville Md.		25b. REGISTRAR'S SIGNATURE [Signature]	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Pr Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr Geo General		d. STREET ADDRESS 4639 Lacy Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILHELMINA SONNTAG		4. DATE OF DEATH Month Day Year Sept 23 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1 1901
9. AGE (in years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Schlarck		14. MOTHER'S MAIDEN NAME Ella Donaldson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. W	
17. INFORMANT LILLIAN SWEENEY		Address 4641 Lacy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Congestive Heart Failure DUE TO (c) Hypertensive C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Simonson Bros. 1661- Good Hope Rd SE Wash DC		24a. REC'D BY REGISTRAR DATE SEP 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION



4.

5

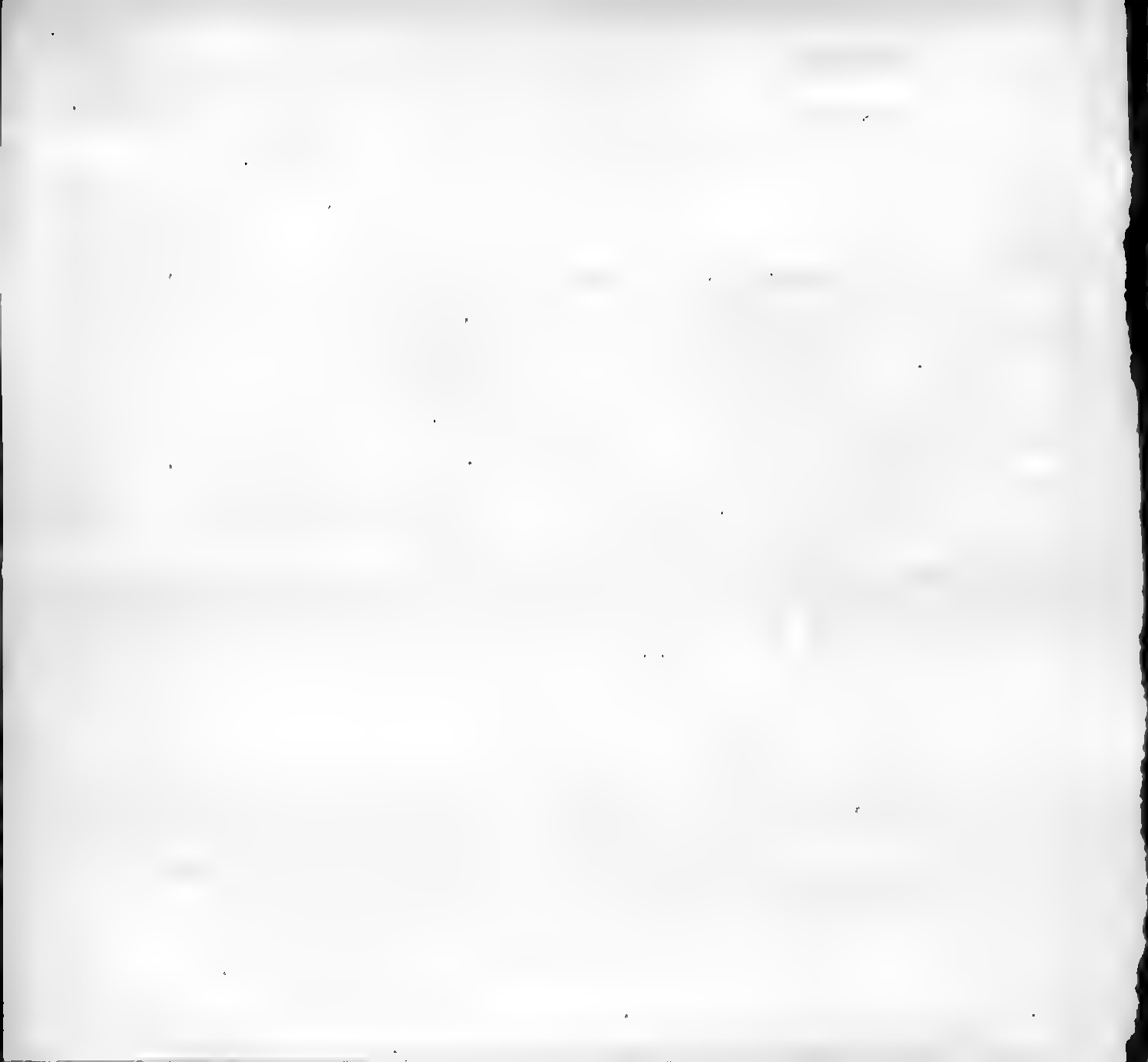
10668

CERTIFICATE OF DEATH

10642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6205 Pontiac St		d. STREET ADDRESS 6205 Pontiac St	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Stanley Stogdale Sr		4. DATE OF DEATH Month Day Year Sept 17, 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1885
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist U S Gov't	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Stogdale		14. MOTHER'S MAIDEN NAME Elizabeth Ann Barrett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 123X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (a) Pulmonary Embolism, marked		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE C. James Duke		M.D. 6607 RIVERDALE RD, RIVERDALE, MD.	
PHYSICIAN'S NAME (Type) C. JAMES DUKE		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 20, 1960	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE SEP 20 '60	
24b. REGISTRAR'S SIGNATURE C. J. James			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

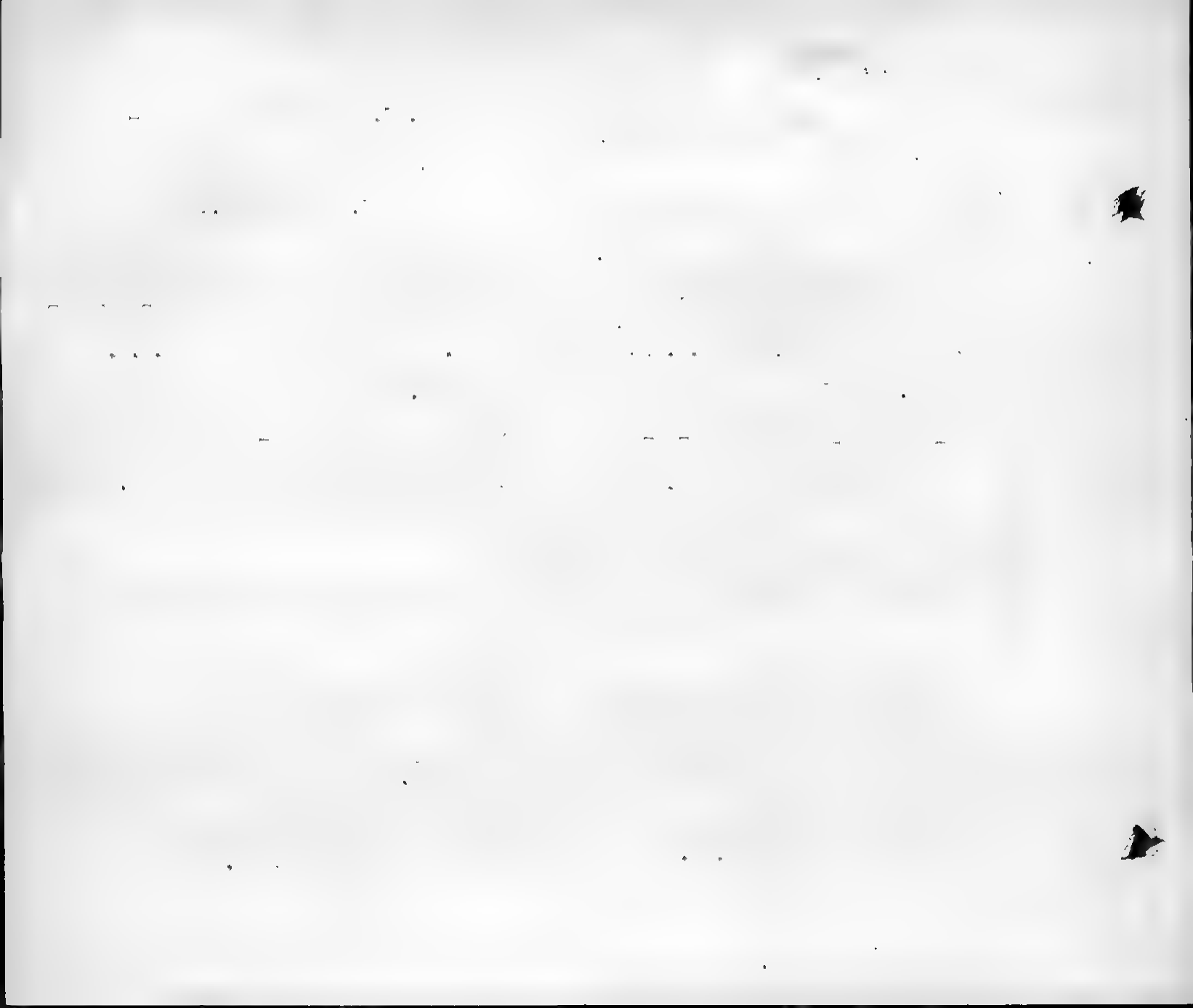
(1)

10669

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10643

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE D. C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1812 N. Capitol St.,			
3. NAME OF DECEASED (Type or print) First Anna Middle E. Last Strickler				4. DATE OF DEATH Month 9 Day 4 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/2/1894	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months — Days —	IF UNDER 24 HRS Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired office worker		10b. KIND OF BUSINESS OR INDUSTRY W.B. Harrison		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James S. Wilson				14. MOTHER'S MAIDEN NAME Mary C. Mackey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 579-01-8718		17. INFORMANT Decedent		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma with generalized metastases DUE TO Conditions, if only which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) 7 months DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 3/4/1960 to 9/4/1960 , that (I) (we) last saw the deceased alive on 9/4/1960 , and that death occurred at 11:10 P. M. from the causes and on the date stated above							
22a. SIGNATURE Moe Weiss		M. D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/4/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept. 6, 60	23c. NAME OF CEMETERY OR CREMATORY Lincoln	23d. LOCATION (City, town, or county) (State) Lincoln Va.				
24. FUNERAL DIRECTOR'S SIGNATURE Bradley Funeral Home			ADDRESS Lincoln Va.	25a. REC'D BY REGISTRAR DATE SEP 7 '60	25b. REGISTRAR'S SIGNATURE William S. Thomas		

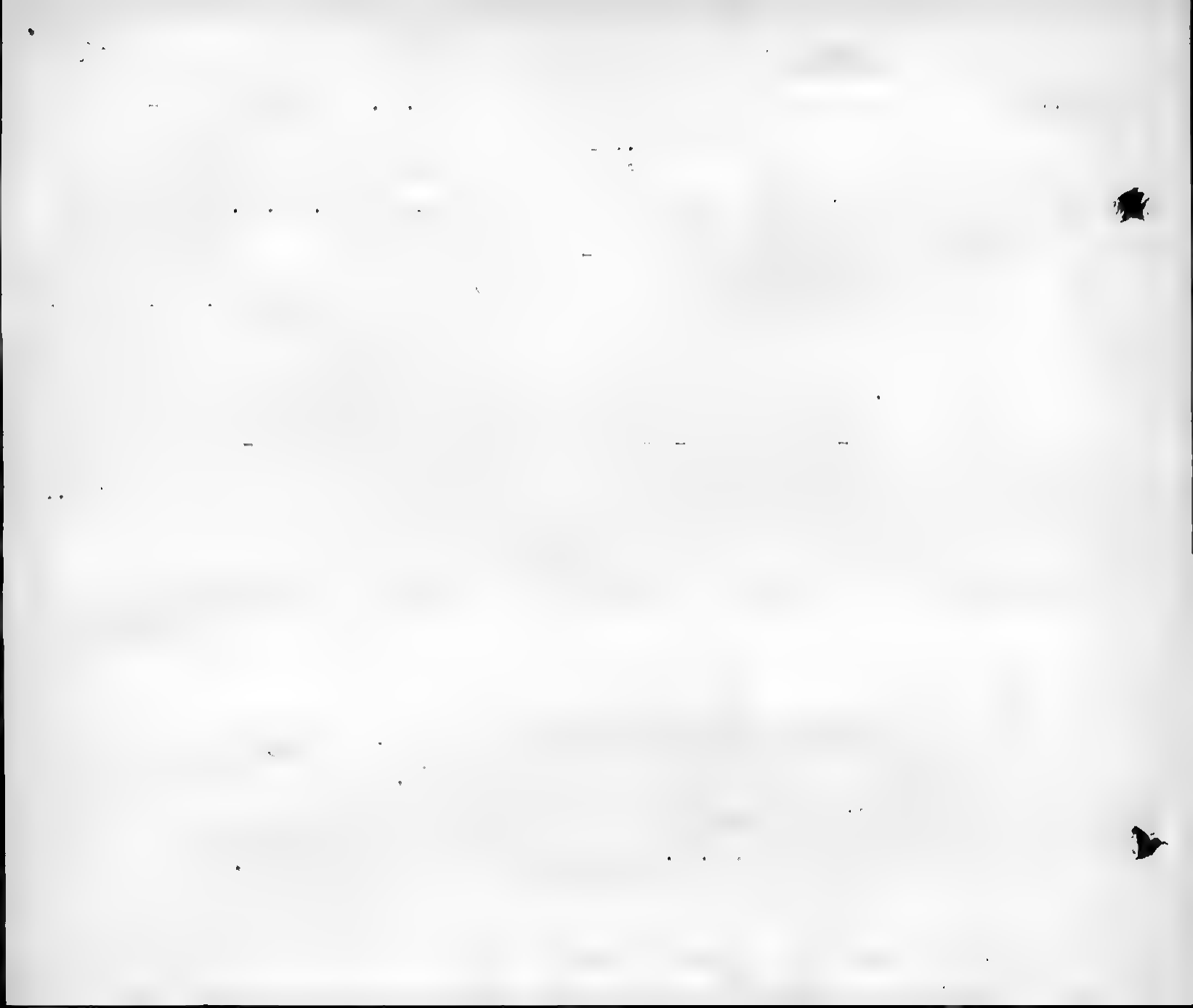


DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10670

10644

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 9 yrs., 11 months, & 21 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 216 5th St., N. E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Harlan Middle - Last Sutton				4. DATE OF DEATH Month 9 Day 25 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/6/1903		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min. -	IF UNDER 24 HRS Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY Saul Chudnow		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George R. Sutton				14. MOTHER'S MAIDEN NAME Luna Harder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 237-14-8130		17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							INTERVAL BETWEEN ONSET AND DEATH 10 yrs.,
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/4/1950 to 9/25/1960 , that (I) (we) last saw the deceased alive on 9/25/1960 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/25/60			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 26 Sept '60		23c. NAME OF CEMETERY OR CREMATORY Greenhills, Inc.		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 44 Massachusetts Ave NE DC				25a. REC'D BY REGISTRAR SEP 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

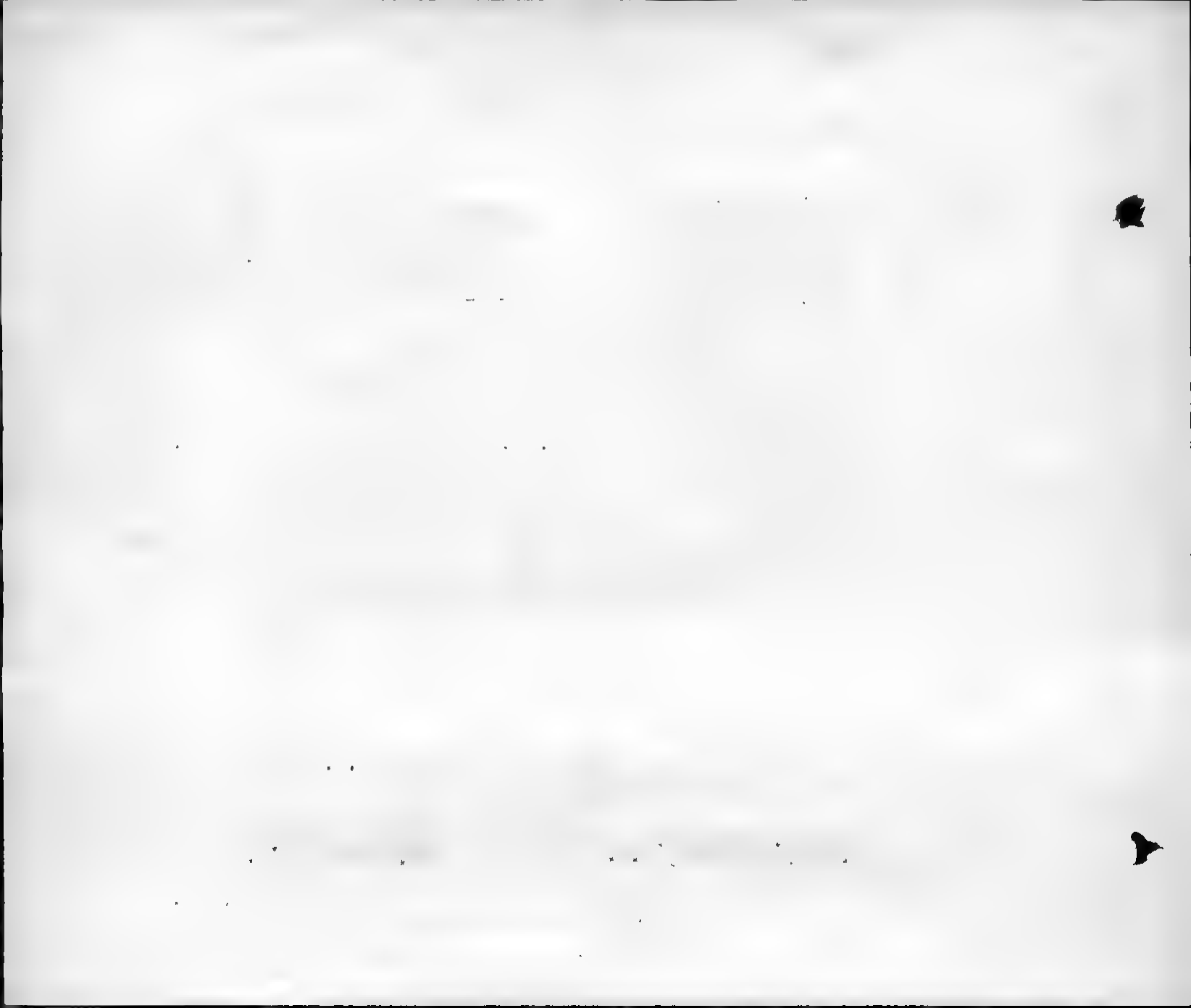
10623

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10645

1 PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. Maryland Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9027 48th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Louise Seal Thomas				4. DATE OF DEATH Month Day Year Sept 12 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-25-99	
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Charles Seal				14. MOTHER'S MAIDEN NAME India Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address C. E. Thomas Jr Beltsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Aortic Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 5 years						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Pneumonia 10 days (Recurring)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o m. p m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1:15 P.M. 19 60 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Waldo B. Moyers				22b. DATE SIGNED 9-12-60			
22c. PHYSICIAN'S NAME (Type) Waldo B. Moyers M.D. Dr. Norman Doney, M.D.				22d. ADDRESS 3503 Perry St. Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/60		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 16 '60	
				25b. REGISTRAR'S SIGNATURE Charles E. Hines			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10646

1. PLACE OF DEATH a. COUNTY Prince Geo MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md b. COUNTY P. George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chenevay		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr Geo General		d. STREET ADDRESS 6138 Kingston Rd	
3. NAME OF DECEASED (Type or print) FRED JAMES THOMPSON		4. DATE OF DEATH Sept 25 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 14 1902
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Andy run Gardening at		10b. KIND OF BUSINESS OR INDUSTRY Washington Dc	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 879-14-9544	
17. INFORMANT Lillian Thompson		Address 6138 Kingston Rd Capital Hts	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Congestive Heart failure / day DUE TO (b) Arteriosclerotic heart DUE TO (c) disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) asthma allurgia, Diabetes Mellitus			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/27/60	22c. NAME OF CEMETERY OR CREMATORIUM Mt Clivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE J. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR SEP 28 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

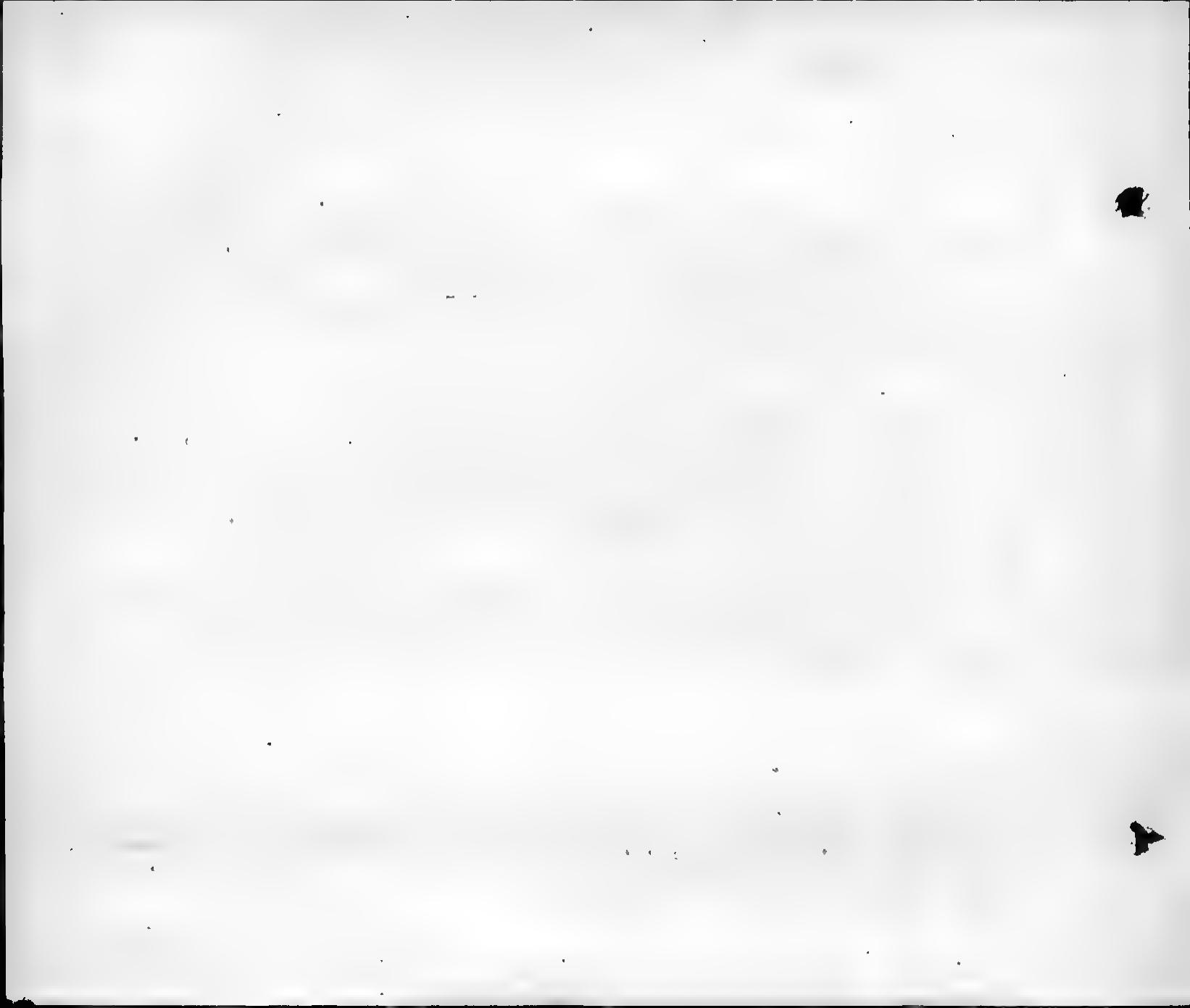
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10625
10647
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 42 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 3808 Allison St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) Lillie First Jane Middle Turner Last				4. DATE OF DEATH Month Sept. Day 3 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-17	9. AGE (In years last birthday) 43 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Kelly				14. MOTHER'S MAIDEN NAME Lillie Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address James Alton Turner Brentwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock secondary to hemorrhage from primary epidermoid carcinoma of the left tonsil. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 12 hours months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atrophic portal cirrhosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Sept. 3 1960	
21 I certify that (I) (this hospital) attended the deceased from Sept 1 1960 to Sept. 3 1960 , that (I) (we) last saw the deceased alive on Sept 3 1960 and that death occurred at 1:30 PM from the causes and on the date stated above							
22a. SIGNATURE Til Bergman				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Til Bergman, M.D.				22d. ADDRESS 6316 Gallen St. Hyattsville, Md.			
23a. BURIAL CREMATION REMOVA. (Specify) Transportation 9/6/60		23b. DATE THEREOF 9/6/60		23c. NAME OF CEMETERY OR CREMATORY Birmingham		23d. LOCATION (City, town, or county) (State) Alabama	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



10671

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (RURAL)		c. LENGTH OF STAY IN 1b 84 DAYS		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC		d. STREET ADDRESS 3320 OAK GLEN WAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Middle Last ROBERT HENRY VREELAND		4. DATE OF DEATH Month Day Year SEPTEMBER 8 1960		5 SEX MALE		6 COLOR OR RACE CAUCASIAN		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 Feb 1884		9. AGE (In years lost birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LUMBER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING		11. BIRTHPLACE (State or foreign country) FARMINGDALE, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT HENRY VREELAND		14. MOTHER'S MAIDEN NAME JENNIE BARRETT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO (If yes, give date of service) NONE		17. INFORMANT Address Mrs. EMMA VREELAND - R.D. #1 - Troy, PA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Branchogenic Carcinoma (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 150 days		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 June, 1960 to 9 Sept, 1960, that I last saw the deceased alive on 8 Sept, 1960, and that death occurred at 11:55 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS		DATE SIGNED 8 SEPTEMBER 1960		ACTUAL SIGNATURE Albert D Carilli		PHYSICIAN'S NAME (Type) ALBERT D CARILLI, CAPT USAF MC		ANDREWS AIR FORCE BASE, WASHINGTON 25 DC		22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF 9/12/1960		22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) TROY - BRADFORD CO. PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS Co - 517-117 St. E. Wash. DC		ADDRESS 517-117 St. E. Wash. DC		24a. REC'D BY REGISTRAR SEP 19 1960		24b. REGISTRAR'S SIGNATURE C. H. S. HARRIS		25. SIGNATURE OF REGISTRAR C. H. S. HARRIS		26. SIGNATURE OF REGISTRAR C. H. S. HARRIS		27. SIGNATURE OF REGISTRAR C. H. S. HARRIS		28. SIGNATURE OF REGISTRAR C. H. S. HARRIS		29. SIGNATURE OF REGISTRAR C. H. S. HARRIS		30. SIGNATURE OF REGISTRAR C. H. S. HARRIS	

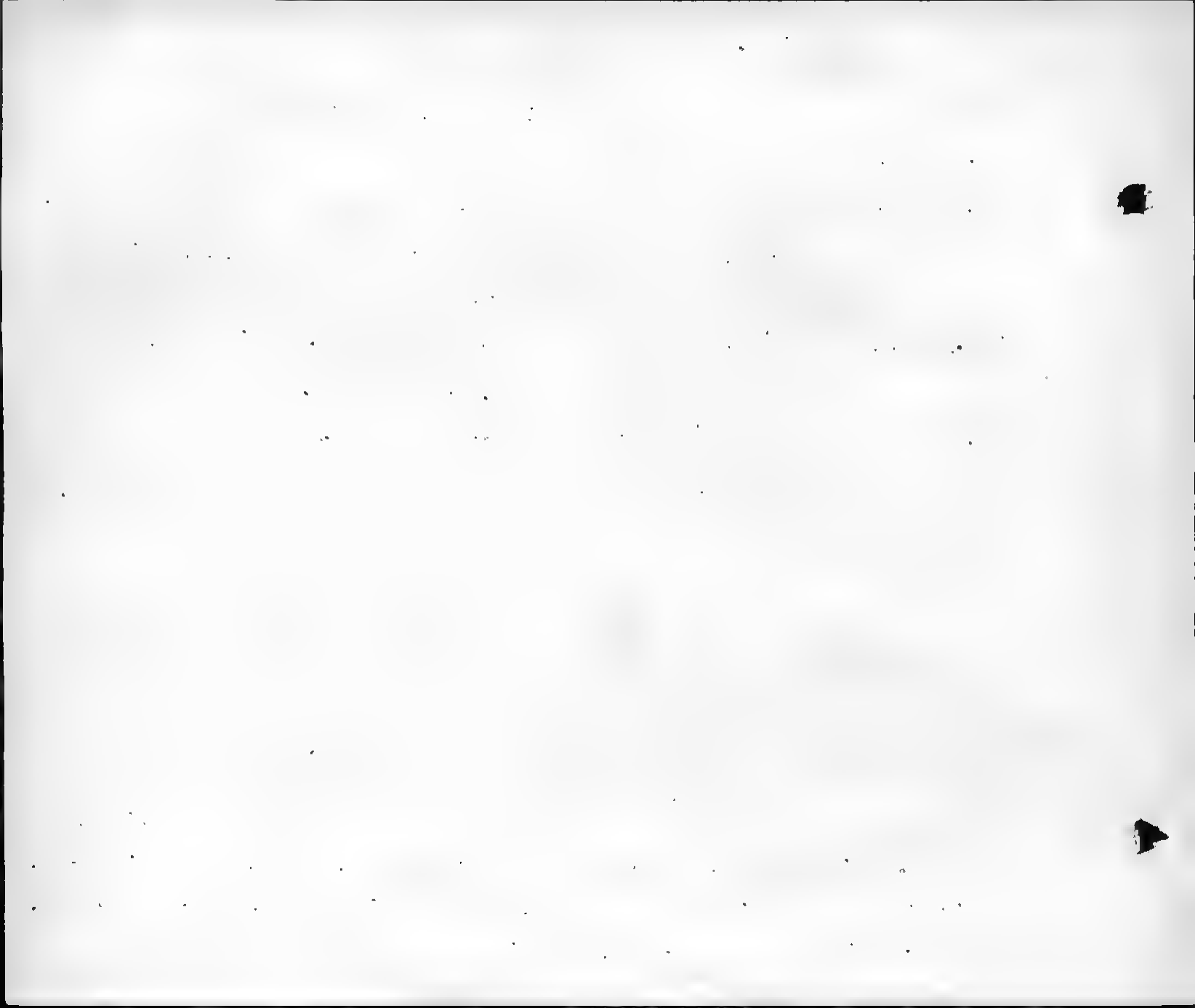
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10672

CERTIFICATE OF DEATH

Reg. Dist. No. 10649

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>DISTRICT OF COL.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, 23, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN TB <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Southern Md. Hosp. Center</u>		d. STREET ADDRESS <u>3000 Parkway Terrace Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Waller</u> Last <u>September 24 1960</u>		4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1875</u>
9. AGE (in years last birthday) <u>84 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>9</u> Days <u>24</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Wardensville W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Tilbury Orndorff</u>		14. MOTHER'S MAIDEN NAME <u>Amanda MC Keever</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Lois Hadra</u>		Address <u>3000 Parkway Terrace Washington 23 D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO <u>clot in lung - 70-70-100</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>—</u> <u>—</u> p. m. <u>—</u> <u>—</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>57</u> , to <u>Sept 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 24</u> , 19 <u>60</u> , and that death occurred at <u>P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis Parker</u> M.D.		DATE SIGNED <u>9/24/60</u>	
PHYSICIAN'S NAME (Type) <u>LEWIS PARKER, MD.</u>		ADDRESS (Street, city or town, state) <u>5241 - ST. BARNABAS RD. WASH. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LEHEW, WEST VA.</u>		22d. LOCATION (City or town, or county) (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hysong Funeral Home</u>		ADDRESS <u>1300-N St. N.W. WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Sept 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

HYSONG FUN. HOME - 1300-N ST. N.W. WASH. D.C.



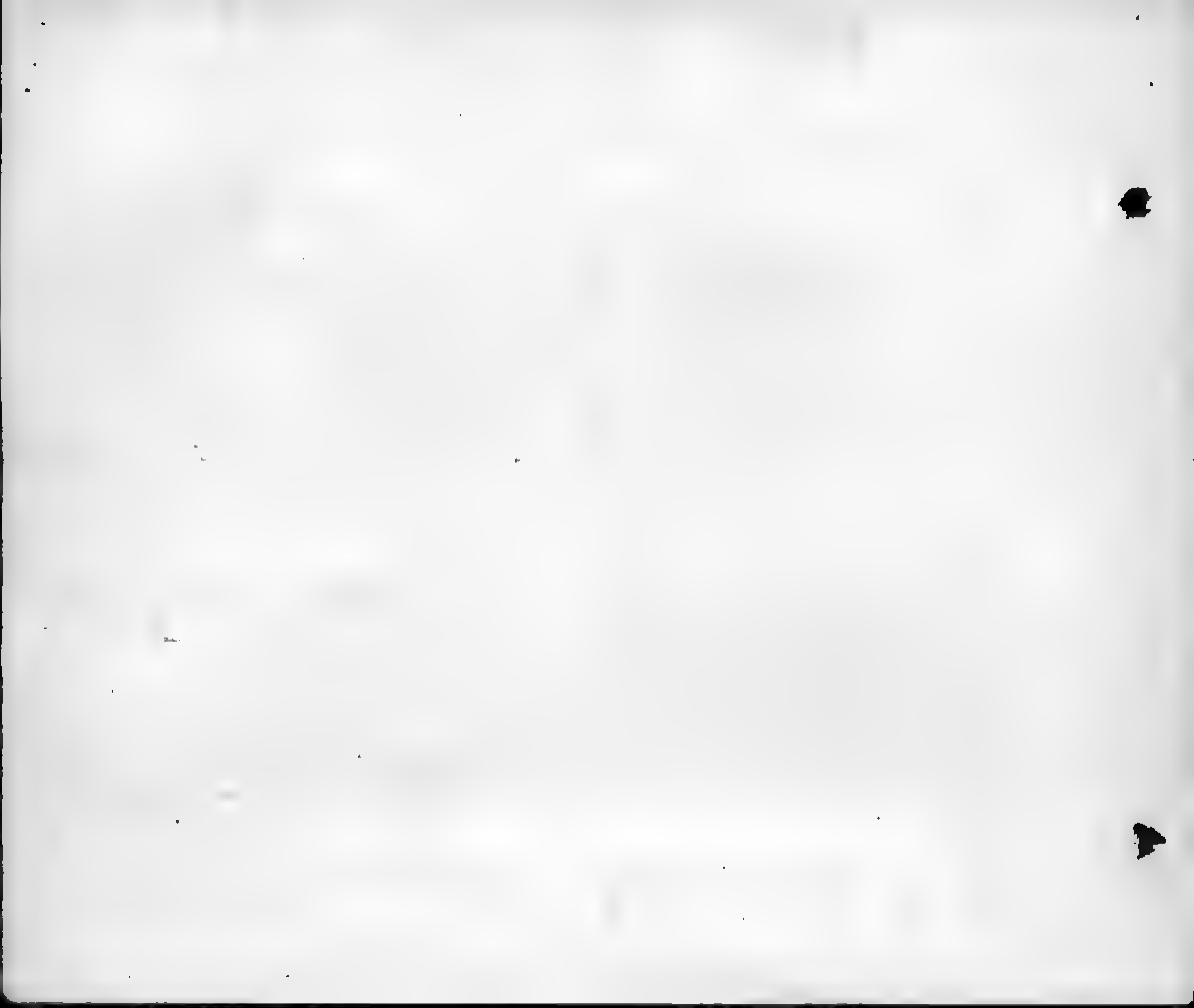
10673

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCOKEEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) i. ACCOKEEK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 13 Maine Street	
3. NAME OF DECEASED (Type or print) Inez E Ward		4. DATE OF DEATH Sept 28 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb 17-1892 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H-house		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Joseph A Thorne		14. MOTHER'S MAIDEN NAME Matilda Thorne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 578-28-1941	
		17. INFORMANT Elsie Roland Address Fish Point Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROTIC HYPERTENSION			INTERVAL BETWEEN ONSET AND DEATH ONE DAY YEARS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPT. 2th, 1960, to SEPT. 28th 1960, that I last saw the deceased alive on SEPT 28th 19 60, and that death occurred at 7:40A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Chen		ADDRESS (Street, city or town, state) ACCOKEEK, MD. DATE SIGNED SEPT. 28th 1960	
PHYSICIAN'S NAME (Type) PAUL CHEN, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9-30-1960	22c. NAME OF CEMETERY OR CREMATORY St Barnabas	22d. LOCATION (City, town, or county) (State) Temple Hills Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Mattingly		ADDRESS 131-11 SE Wash DC	24a. REC'D BY REGISTRAR SEP 29 '60
			24b. REGISTRAR'S SIGNATURE R. A. S. Thorne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

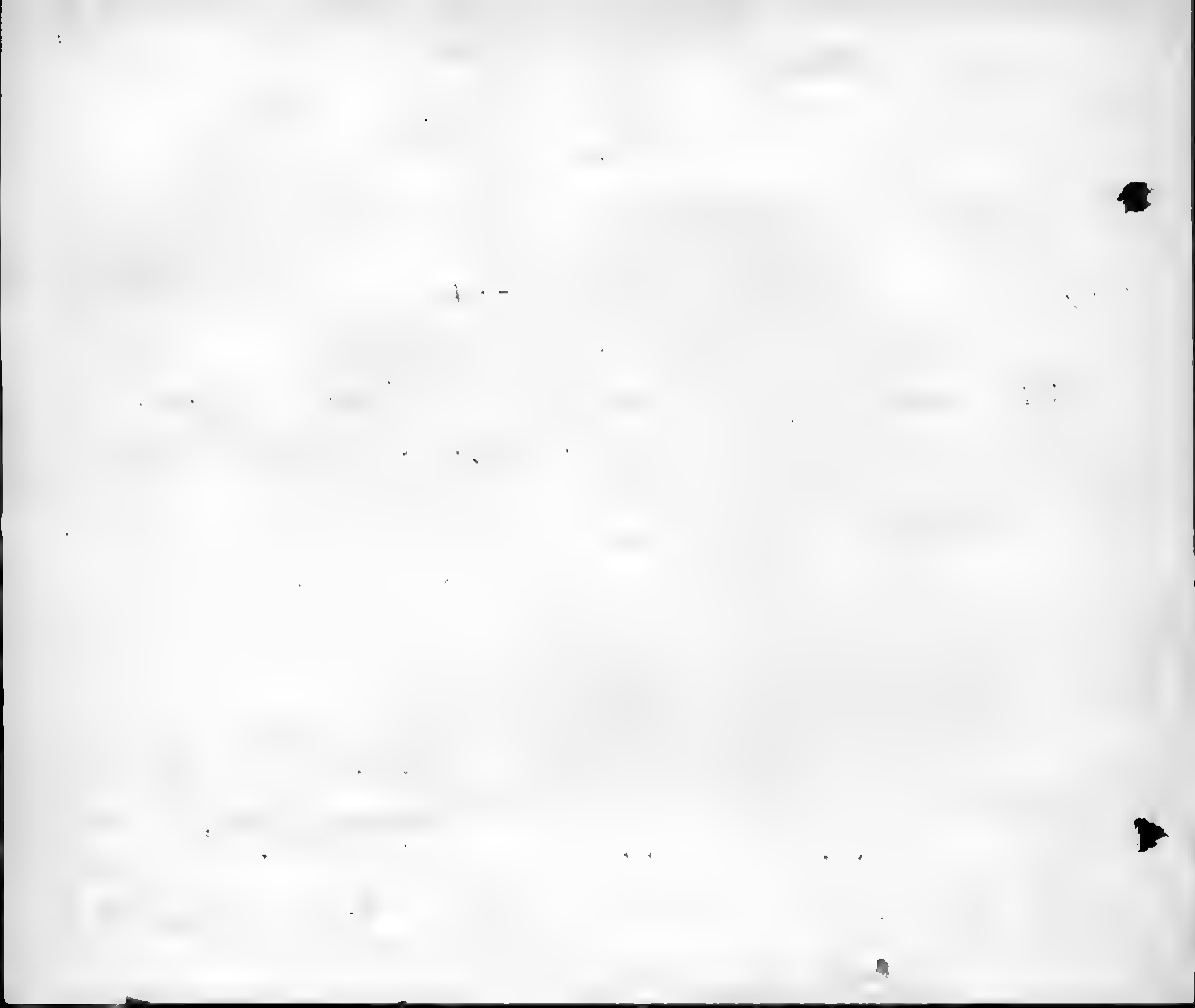
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10651

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 23 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lawrence Middle L Last Wedding				4. DATE OF DEATH Month Sept Day 9 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-03	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 9 Days 19 Hours 60	IF UNDER 24 HRS Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Wedding				14. MOTHER'S MAIDEN NAME Mary Bowie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or status of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mary J. Wedding				Address 7801 Glenside Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CORONARY THROMBOSIS DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH MOMENTS 1-2 HOURS UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/15 , 19 60 , to Sept 9 , 19 60 , that (I) (we) last saw the deceased alive on 9/8 , 19 60 , and that death occurred at 6:50 A. M. from the causes and on the date stated above							
22a. SIGNATURE C. James Duke				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/9/60	
22c. PHYSICIAN'S NAME (Type) Dr. C. James Duke, M.D.				22d. ADDRESS 6607 Riverdale Road, Riverdale, Md.			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Buried		9-12-60		Fort Lincoln		Bladensburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME				ADDRESS 4812 Ga Ave NW DC		25a. REC'D BY REGISTRAR DATE SEP 15 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

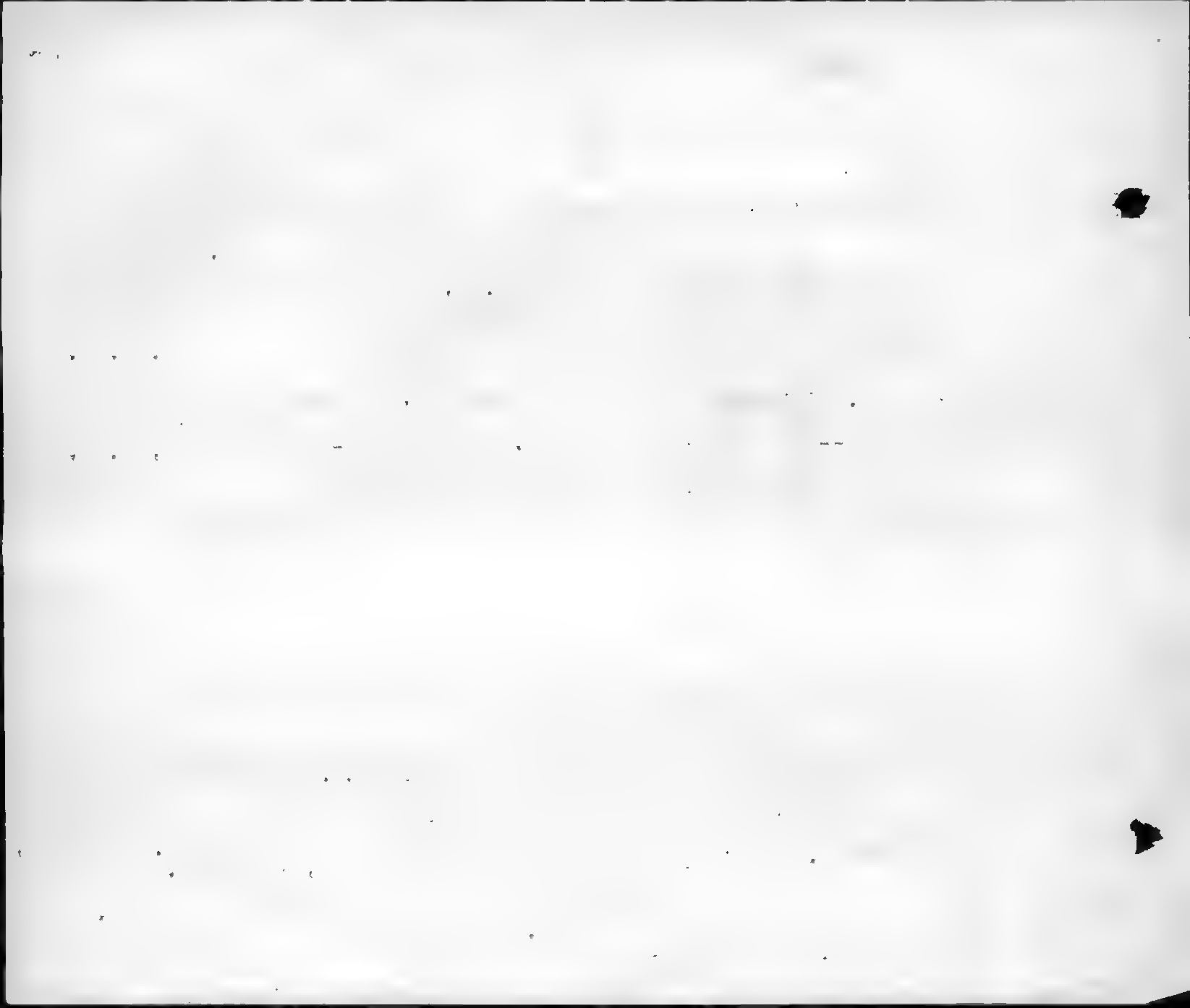


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1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if infirmity Residence should be addressed) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. STREET ADDRESS 6705 Central Avenue	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Rebecca Last Wells		4. DATE OF DEATH Month Sept. Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1880
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 11 Days 24 Hours 45	11. IF UNDER 24 MRS Months 11 Days 24 Hours 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Reverdy R. Nicholson		14. MOTHER'S MAIDEN NAME Mary R. Tydings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Marie Allen		Address 2233 R Street Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO-VASC. DISEASE DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-2 1960 to 9-13 1960 ; that (I) (we) last saw the deceased alive on 9-13 1960 , and that death occurred 10:15 pm on the causes and on the date stated above.			
22a. SIGNATURE Max M. Herzberg		22b. DATE SIGNED 9/14/60	
22c. PHYSICIAN'S NAME (Type) Max M. Herzberg		22d. ADDRESS Prince Georges' Gen. Hospkta Cheverly, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/17/60	
23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		23d. LOCATION (City, town, or county) (State) Forestville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper		25a. REC'D BY REGISTRAR SEP 21 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Kraw			

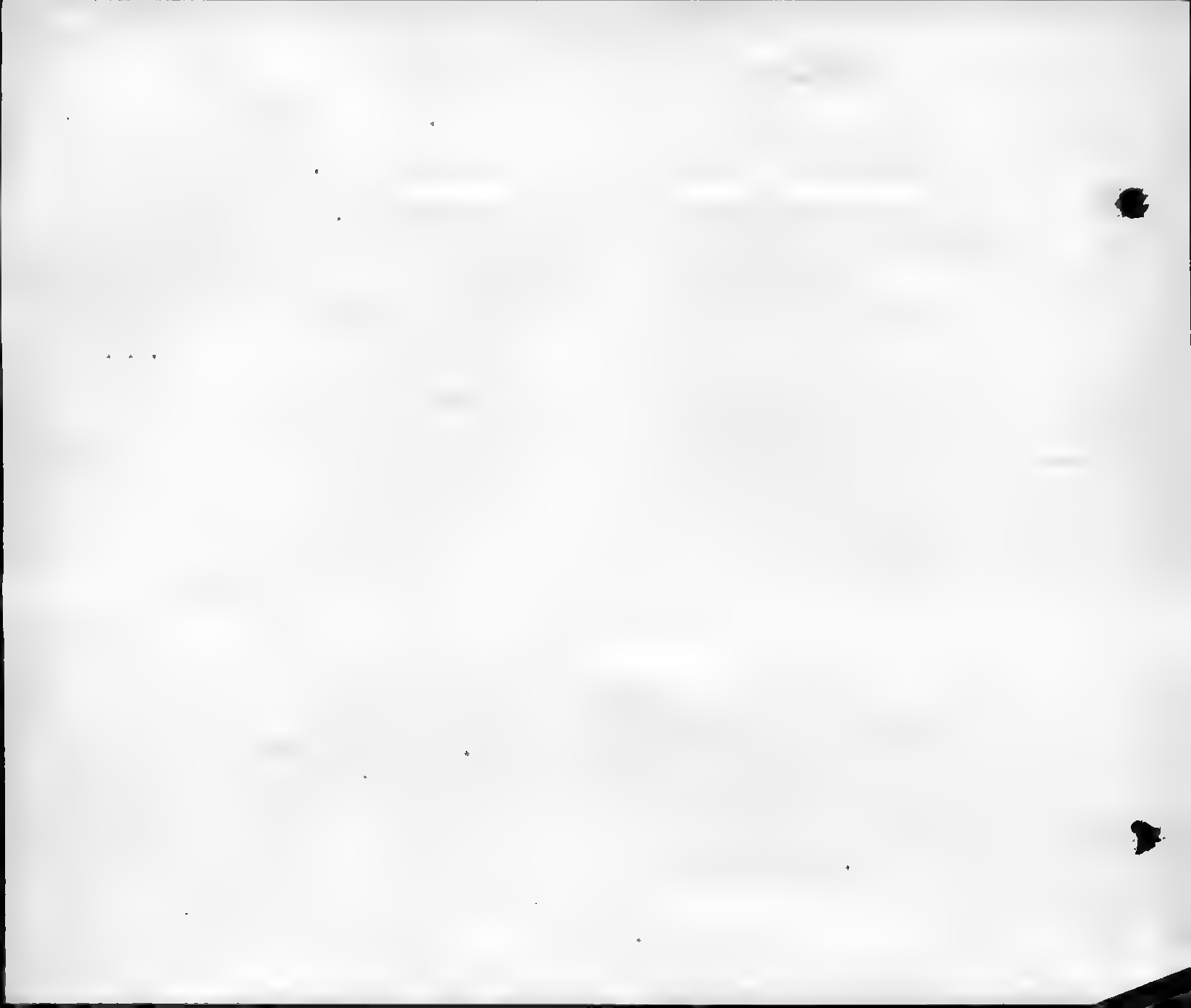


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10628

10653

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md				c. LENGTH OF STAY IN 1b 17 Hr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS Hyattsville, Md. 1504 Decatur St.			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle White Last White				4. DATE OF DEATH Month Sept Day 6 Year 19 60			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5-60	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. 12 Hrs 5 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John White				14. MOTHER'S MAIDEN NAME DeLois Brinkley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mother Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 712-3 DUE TO Intellectual Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Sept. 5, 19 60 to Sept 6, 19 60 , that (I) (we) last saw the deceased alive on Sept 6, 19 60 , and that death occurred on 8:15 AM from the causes and on the date stated above		22a. SIGNATURE John Perkins M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9/7/60	
22c. PHYSICIAN'S NAME (Type) Dr. Perkins		22d. ADDRESS 5301 Haulter St. Hyattsville, Md		23a. REC'D BY REGISTRAR Harry W. Penn, Jr. Administrator		23b. REGISTRAR'S SIGNATURE Charles S. Kline	
23c. BURIAL, CREMATION REMOVAL (Specify) Cremation		23d. DATE THEREOF 9-30-60		23e. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Maryland		23f. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		25a. REC'D BY REGISTRAR OCT 4 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kline		25c. DATE	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Coroner notified and approved by phone-9-30-60

10629

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10654

1. PLACE OF DEATH a. COUNTY Pr. George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. LENGTH OF STAY IN 1b 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights	
3. NAME OF DECEASED (Type or print) BERTRAND First Middle E. Last WHITNEY		4. DATE OF DEATH Sept. 30th. 1960 Year 19 Month Sept. Day 30th.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't Clerk		10b. KIND OF BUSINESS OR INDUSTRY Laceyville Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Whitney		14. MOTHER'S MAIDEN NAME Minanda Moyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 172 22 4961	
17. INFORMANT Miss Sadie Whitney		Address 5500 Parkland Ct. S.E. District Hghts, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 10 mins INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (We) attended the deceased from Feb 1959 to 9/30 1960 that (I) (we) last saw the deceased alive on 9/28 1960 and that death occurred on 9/30 1960 from the causes and on the date stated above.			
22a. SIGNATURE Kelvin L. Minchin		22b. DATE SIGNED 5/4/61	
22c. PHYSICIAN'S NAME (Type) Kelvin L. Minchin		22d. ADDRESS 7400- Marlboro, Pike District Hghts, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10/5/60		23b. DATE THEREOF 10/5/60	
23c. NAME OF CEMETERY OR CREMATORY Laceyville Cem.		23d. LOCATION (City, town, or county) (State) Laceyville, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Washington D.C.		25a. REC'D BY REGISTRAR OCT 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10655

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Hgts.				c. LENGTH OF STAY IN 1b 7121 - Cabot St/			
d. NAME OF HOSPITAL (If not in hospital, give street address) 7121 Cabot St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle B. Last WINCHESTER				4. DATE OF DEATH Month Sept. Day 18, Year 1960			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1888	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.		IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY aryalne		11. BIRTHPLACE (State or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Marriott				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE		17. INFORMANT James W Winchester- same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ch suppurates DUE TO Ch chest reflux Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch chest reflux DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- 19 p. m. ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1960 to Sept 18, 1960 that (I) (we) last saw the deceased alive on Sept 17, 1960 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE AK Boxie				22b. DATE SIGNED Sept 18, 1960			
22c. PHYSICIAN'S NAME (Type) AK BOXIE				22d. ADDRESS 301 Court Ave N E			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-21-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home- Washington D.C.				25a. REC'D BY REGISTRAR DATE SEP 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

